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### A Pilot Program Evaluating The Acceptability And Feasibility Of A Health Care Ethics Curriculum For Critical Care Nurses

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**A PILOT PROGRAM EVALUATING THE ACCEPTABILITY AND FEASIBILITY OF  
A HEALTH CARE ETHICS CURRICULUM FOR CRITICAL CARE NURSES**

Submitted to the Faculty  
Yale University School of Nursing

In Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Nursing Practice

Jennifer Rebekah Rendon

April 20, 2020

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This DNP Project is accepted in partial fulfillment of the requirements for the degree Doctor of Nursing Practice.

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### Abstract

**Background:** Critical care units are demanding practice settings filled with daily stressors including the ethical climate (America Association of Critical-Care Nurses 2015a; Mealer, & Moss, 2016). Navigating this ethically sensitive area requires critical care nurses have an understanding of ethics at a level appropriate for their practice setting (Bertolini, 1994; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Indhraratana & Kaemkate, 2012; Mealer, & Moss, 2016; Rushton & Stutzer, 2015; Schluter, Winch, Holzhauser, & Henderson, 2008; Sellman, 1996). However, current ethics education for critical care nurses is limited to a general understanding of basic ethical principles (American Association of Colleges of Nursing, 2008; National League for Nursing [NLN], 2016; Nursing & Midwifery Council [NMC], 2010). Critical care nurses subsequently report their ethics training to be inadequate leaving them struggling to meet the challenges of their practice area (Bicking, 2011; Choe, Kang, & Park, 2015; Hughes & Dvorak, 1997). Addressing the lack of critical care-specific ethics education would provide a means by which critical care nurses can acquire skills appropriate for their practice setting. Currently, there is no practical, specialty specific, health care ethics education modality for critical care nurses.

**Objective:** The goal of this Doctor of Nursing Practice project was to provide a means by which registered nurses can gain knowledge in health care ethics specific to critical care settings. This goal was realized through three measurable aims: (1) the development of a critical care-specific ethics curriculum, (2) refinement and validation of the curriculum content by expert panel and, (3) implementation and evaluation the curriculum.

**Methods:** The project began with the development of a curriculum utilizing the Whittemore, & Knafl, (2005) integrative review methodology along with a one-step modified Delphi panel. The

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curriculum was then refined and validated by expert panel. Once refinement and validation were complete, the curriculum was placed in a web-based format, uploaded onto a web-based learning platform and made available as a pilot program to the membership of the American Association of Critical-Care Nurses. The pilot ran from January 2020 through February 2020. Data was collected on (1) the number of eligible critical care nurses who consent to participate and (2) the number who complete the curriculum. A comparison analysis of this data was used to evaluate feasibility. Participants who complete the curriculum were given an online course evaluation to collect data on their perceptions regarding the curriculum's value to practice, the efficacy of course delivery, and overall satisfaction with the course. Analysis of the evaluations was used to evaluate acceptability.

**Results:** Twenty-seven eligible participants signed up for the pilot and four completed the course indicating that 14.8% of the respondents completed the course. The majority of the respondents ( $\geq 50\%$ ) believed the course: (1) increased the critical care nurse's knowledge of health care ethics, (2) was delivered in a method appropriate for the content presented, (3) that the content was valuable to their practice, and (4) were overall satisfied with the course.

**Discussion:** The preliminary results indicate that using a professional organization to facilitate a self-paced, online program may not be the best modality for teaching health care ethics to critical care nurses. Furthermore, the lack of an instructor's presence, the self-paced online format, and the two-month time period the participants were given to complete the course may have also contributed to the low completion rates. These findings suggest a need for further research on nursing specific health care ethics teaching modalities in the critical care setting.

Keywords: critical care, critical care nurse, health care ethics, curriculum

Jennifer Rendon

Doctor of Nursing Practice Project: Ethics Education for Critical Care Nurses

Yale University School of Nursing

Dr. Mark Lazenby, Advisor

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Chapter One: The Problem and its Significance

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### Introduction

There are over 500,000 critical care nurses in the United States (Society of Critical Care Medicine, 2015) providing bedside nursing care to patient populations that are at the highest risk for severe physiological instability (Marshall et al., 2017). Accordingly, these nurses receive specialized training aimed at preparing them to provide the level of care appropriate for patients with complex, life-threatening clinical presentations (American Association of Critical Care Nurses [AACN], 2015a). This preparation encompasses more than the acquisition of technical knowledge and skill. The critical care nurse must also learn how to navigate the critical care environment (AACN, 2015a). It is a demanding practice setting filled with daily stressors with which critical care nurses must learn to cope (AACN, 2015a; Mealer & Moss, 2016). Included in these daily stressors is the ethical climate of the intensive care unit (Mealer & Moss, 2016).

### Statement of the Problem

Ethical dilemmas permeate the critical care setting (Holly, 1993; Luce & White, 2009; Moon & Kim, 2015; Park, Jeon, Hong, & Cho, 2014; Soderberg & Norberg, 1993). Advances in medicine and changing societal norms have come together to create a critical care ethical climate in which the ethical principles of autonomy, beneficence, nonmaleficence, and justice often come into conflict (Holly, 1993; Luce & White, 2009; Shragg & Albertson, 1984). Navigating the ethically sensitive critical care area requires that critical care nurses have an understanding of these ethical principles and be skilled in their application (Bertolini, 1994; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Indhraratana & Kaemkate, 2012; Robichaux, 2012; Rushton & Stutzer, 2015; Schluter, Winch, Holzhauser, & Henderson, 2008; Sellman, 1996). However, current ethics education for critical care nurses is limited to a general understanding of ethics provided in pre-licensure programs (American Association of Colleges of Nursing, 2008;

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National League for Nursing [NLN], 2016; Nursing & Midwifery Council [NMC], 2010).

Studies suggest that this preparation is inadequate to meet the challenges of the critical care area (Bicking, 2011; Choe, Kang, & Park, 2015; Hughes & Dvorak, 1997).

### Significance of Addressing the Problem

Critical care nurses struggle to apply ethics at a level appropriate for their practice setting (Bicking, 2011; Callister, Luthy, Thompson, & Memmott, 2009; Dierckx de Casterle, Izumi, Godfrey, & Denhaerynck, 2008; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Indhraratana & Kaemkate, 2012; Rushton, & Stutzer, 2015; Vanlaere & Gastmans, 2007). This is a problem of moral significance. Arguably, the most well-known moral concern stemming from this problem is that of moral distress, the internal conflict an individual perceives when unavoidable circumstances prevent him or her from acting according to his or her beliefs of right and wrong (Jameton, 1984). A lack of training in critical care specific ethics contributes to critical care nurses' experience of moral distress and is highly concerning as moral distress has been shown to lead to severe burnout (Fumis, Amarante, Nascimento, & Vieira, 2017; Henrich et al., 2017; Mealer & Moss, 2015), feelings of low self-worth, poor patient care (Choe et al., 2015; Henrich et al., 2017; Mealer & Moss, 2016; Wilkinson, 1987), and high staff turnover rates (Choe et al., 2015; Mealer & Moss, 2016). However, I propose another equally concerning moral consequence to the problem that arises from a lack of critical care specific ethics training, namely that of moral injury. Moral injury is the lived experience of mental suffering in the face of demoralization (Bernstein, 2015) and occurs when an individual participates in an action that they recognize is morally wrong but do so because the action has been justified by a legitimate body of authority (Gilligan, 2014; Shay, 2014). I suggest that the lack of adequate critical care

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specific ethics education for nurses contributes to an ethical milieu that fosters the perpetration of a moral injury against critical care nurses.

The injury finds its origins in critical care nurses' threatened perceptions of self. Due to the limitations imposed upon them by life-threatening illness, critically ill patients in the intensive care units are unable to meet their basic needs and depend on the nursing care critical care nurses provide (Danis & Patrick, 2002). In their role as nursing professionals, critical care nurses assume responsibility of these vulnerable individuals (Allmark, 2005; Callister et al., 2009; Hadjibalassi et al., 2012; Indhrraratana & Kaemkate, 2012; Nilstun, Cuttini, & Saracci, 2001; Robichaux, 2012). This responsibility is a moral responsibility because it is based on the trust inherent to the nurse-patient relationship or the moral habit of trustworthiness (Lazenby, 2017). Patients place their trust in nurses because they have confidence that nurses possess the skills necessary to care for them (Lazenby, 2017). In turn, nurses participate in activities that validate this confidence thereby embodying trustworthiness (Lazenby, 2017).

Unfortunately, critical care nurses believe that they lack the ethical knowledge and skills competency needed to function optimally in the critical care environment (Bicking, 2011; Callister et al., 2009; Dierckx de Casterle et al., 2008; Hadjibalassi et al., 2012; Hough, 2008; Hughes & Dvorak, 1997; Indhrraratana & Kaemkate, 2012; Rushton, & Stutzer, 2015; Vanlaere & Gastmans, 2007). This perception of inadequacy threatens critical care nurses' belief in their ability to embody trustworthiness and alters their perception of self. They perceive they are ill-equipped and unable to fulfill their moral duty as trusted care providers and advocates for what is inherently and rationally understood as morally correct or the moral right (McInerny, 1997). This inner demoralization is a breakdown of the critical care nursing community's nursing ethos and the perpetration of the moral injury.

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There is at this time no widely available practical means by which critical care nurse can remedy this demoralization or work towards affirming trustworthiness. I propose that this moral injury can be remedied by helping critical care nurses restore trustworthiness and mend their fractured ethos. The solution lies in addressing the lack of specialty specific ethics education for critical care nurses; this project aims to do just that.

Chapter Two: Context

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### Review of the Literature

#### **Introduction**

Formal nursing education is grounded in ethics education. The first professional nursing training programs developed by Florence Nightingale prioritized shaping student nurses' individual morality and placed the instruction of scientific based nursing skills second in importance (Holliday & Parker, 1997; Hoyt, 2010; Sellman, 1997). Nightingale believed moral character development or the development of a personal ethic was the most important aspect of a nurses' education and without a solid ethos guiding practice, nursing care was lacking (Holliday & Parker, 1997; Hoyt 2010; Sellman, 1997). The nursing leaders that came after Nightingale continued this legacy. For example, Annie Goodrich, the founder of Yale School of Nursing, grounded the school in ethics based on her conviction that good nursing and ethical nursing were one and the same (Goodrich, 1973).

Today's nursing education has shifted its priority to the acquisition of practical knowledge and skills (Hoyt, 2010; Sellman, 1997; Schluter et al., 2008; Taylor, 1995). However, ethics content remains an important part of professional nursing baccalaureate programs (American Association of Colleges of Nursing, 2008; NLN, 2016; NMC, 2010). While not considered a stand-alone "essential", ethics content can be found within all "nine essential" core knowledge categories within the American Association of Colleges of Nursing's publication, *The Essentials of Baccalaureate Education for Professional Nursing Practice* (2008). This publication is the gold standard for professional nursing education and guides the development of curriculums that will build "the knowledge, skills, and attitudes" an entry level nurse generalist will need "to fulfill the role of care provider, designer/manager/coordinators of care and professional member" (American Association of Colleges of Nursing, 2008). The

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objective of this discourse is to review the literature on the preparation of nurses in ethics specific to the critical care practice setting. The research question this review attempts to answer is: Does the required ethics content nurse generalists receive in baccalaureate programs prepare them for specializing in critical care, or is critical care-specific ethics training necessary?

### **Synthesis of the Literature**

#### **Search Strategy**

A search of the literature was designed based on the research question: Is the required ethics education of the baccalaureate-prepared nurse generalist adequate preparation for the critical care practice setting, or is critical care-specific ethics training necessary? Databases were searched October 2017 to December of 2017 and included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Sociological Abstracts database, the Educational Resources Information Center (ERIC), the PAIS Index, and PubMed/MEDLINE. Search terms included “nurses,” “registered nurses,” “critical care,” “intensive care,” “health care ethics,” “bioethics,” “ethics,” “morals,” “education,” “curriculum,” and “competency.” Ninety-one articles fit the search criteria; however, only 34 were included in the review. Nineteen articles were excluded from the review due to their limited scope in addressing only one aspect of ethics education (e.g. end-of-life issues, informed consent, ethics consultation); 17 were excluded because they did not focus on nursing in the acute setting; 13 were excluded because they discussed intensive care unit (ICU) training without a focus on ethics; 3 were excluded because they were not available in English; and 5 were excluded because they were case reports and not transferable. Date of publication was not a factor in article selection. The articles were reviewed and analyzed for themes.

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Five major themes resulted; they were: ethics is a necessary component of nursing knowledge; ethics is a part of critical care nursing practice; critical care nurses are inadequately prepared for the ethical situations they encounter; there is a lack of agreement on the development of ethics education for critical care nurses; and barriers to ethics education.

### **Ethics as a Necessary Part of Nursing**

A major theme that emerged from the literature review is that ethics is a necessary component of a nurse's core knowledge base (AACN, 2008; Allmark, 2005; Bertolini, 1994; Biking, 2011; Caldicott & Braun, 2011; Callister et al., 2009; Gastmans, 2002; Hadjibalassi et al., 2012; Hubert, 1999; Hughes & Dvorak, 1997; Indhrraratana & Kaemkate, 2012; Jaeger, 2001; Nilstun et al., 2001; Robichaux, 2012; Ruston & Stutzer, 2015; Sellman, 1997). Several subthemes emerged that support this assertion and they build upon each other to form one robust claim.

**Moral Enterprise.** The first subtheme maintains Nightingale's belief that nursing is a moral enterprise (Holliday & Parker, 1997; Hoyt, 2010; Sellman, 1997) adding that the proximity to patient care situations and the intimacy that develops between the bedside caregiver and patient confers upon nurses a moral obligation to develop skills that increase their moral accountability (Bertolini, 1994; Biking, 2011; Hoyt 2010; Indhrraratana & Kaemkate, 2012; Schluter et al., 2008; Sellman, 1996, 1997).

**Moral Accountability.** The second subtheme extends this idea of moral accountability to include the fulfillment of a nurses' professional role. In order for the professional nurse to act as "care provider, designer/manager/coordinator and professional member" (AACN, 2008), a nurse must have the moral character to assume moral accountability (Allmark, 2005; Callister et al.,

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2009; Hadjibalassi et al., 2012; Indhrratana & Kaemkate, 2012; Nilstun et al., 2001; Robichaux, 2012).

**Moral Sensitivity.** The third subtheme that emerged from the review is the concept of moral sensitivity as it relates to the professional role. Moral sensitivity is the ability to see a potential ethical problem and the skill of ethical dilemma recognition. Individuals who possess moral sensitivity understand that there is no universal value system guiding decision making and that working towards reconciliation of a decisional conflict begins with acknowledging the involved parties' different beliefs (Jaeger, 2011; Wilkinson, 1987). The literature maintains that the propensity for ethical conflict in the nurse's daily work environment requires nurses be morally sensitive (Duckett & Ryden, 1994; Esmaelzadeh, Abbaszadeh, Borhani, & Peyrovi, 2016; Jaeger, 2011; Lützén, Cronqvist, Magnusson, & Andersson, 2003; Lützén, Dahlqvist, Eriksso, & Norberg, 2006) and that this skill can be enhanced by ethics education (Duckett & Ryden, 1994; Sirin, Brabeck, & Rogers-Serin, 2003). Bringing these themes together, the consensus is clear that to effectively fulfill his or her professional role, a nurse must receive training that facilitates the development of moral character, accountability, and sensitivity.

### **Ethics as a Necessary Part of Critical Care Nursing**

Another major theme that emerged is that ethics preparation is even more crucial for critical care nurses (Bertolini, 1994; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Indhrratana & Kaemkate, 2012; Robichaux, 2012; Rushton & Stutzer, 2015; Schluter et al., 2008; Sellman, 1996). Two subthemes emerged that coalesce to form one argument about the necessity of ethics training for critical care nurses.

**The critical care environment.** The first and most prevalent subtheme concerns the nature of critical care services and the role of critical care nurses in providing these services.

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Advances in medicine have created a critical care environment where questions of autonomy, beneficence, nonmaleficence and justice often come into conflict (Schluter et al., 2008).

Medicine is no longer limited to alleviating sickness, it can now artificially sustain life.

Mechanical ventilation, intravenous hydration, and enteral nutrition are among the most common life sustaining treatments prescribed (Luce & White, 2009). Decisions regarding initiation or cessation of these treatments occur daily and can become the center of debate when the parties involved have conflicting value systems (Luce & White, 2009; Moon & Kim, 2015; Park et al., 2014; Shragg & Albertson, 1994; Soderberg & Norberg, 2008). Societal attitudes towards health care services have also changed the delivery of critical care services. The once acceptable paternalistic medical approach that negated the need to reconcile provider and patient values is no longer accepted practice (Luce & White, 2009). Patients want to be informed and involved in all health care related decisions and providers are morally obligated to respect these decisions even when in disagreement (Luce & White, 2009; Shragg & Albertson, 1994). Navigating this environment is challenging for critical care nurses, nevertheless, it must be done successfully in order to fulfill the expectation of moral accountability to the patient that is a fundamental part of the professional nursing role (Bertolini, 1994; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Indhraratana & Kaemkate, 2012; Robichaux, 2012; Rushton & Stutzer, 2015; Schluter et al., 2008; Sellman, 1996). Therefore, to function effectively critical care nurses must receive training that facilitates the development of moral character, accountability, and sensitivity on a level suited for their practice.

**Moral Distress.** The second subtheme concerns the concept of moral distress and the critical care environment. Moral distress is the lived experience of a perceived ethical dilemma. It is the internal conflict an individual perceives when unavoidable circumstances prevent him or

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her from acting according to his or her beliefs of right and wrong (Jameton, 1984). Moral distress is of great concern to professional nursing as it has been found to be associated with severe burn out (Fumis et al., 2017; Henrich et al., 2017), high staff turnover rates (Choe et al., 2015), diminished feeling of self-worth, physical and psychological ailments, and most concerning, poor patient care (Choe et al., 2015; Henrich et al., 2017; Wilkinson, 1987). The nature of the critical care environment, with its propensity for unresolved ethical dilemmas that results in nurses experiencing moral distress, requires that nurses working in this environment receive training that develops moral sensitivity and the skills to address ethically challenging situations (Bertolini, 1994; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Indhrraratana & Kaemkate, 2012; Lützén et al., 2003; Robichaux, 2012; Rushton & Stutzer, 2015; Sellman, 1996). In other words, critical care nurses must understand ethical principles and have the skill to apply them to patient care situations. Failure to do so leaves arguably the most vulnerable patients, the critically ill, at risk for suboptimal care and the critical care nurse in dereliction of his or her professional role.

### **Inadequacy of Ethics Preparation**

Educational based interventions have been found to improve nurses' understanding of ethics and its application to patient situations (Bicking, 2011; Callister et al., 2009; Duckett & Ryden, 1994; Indhrraratana & Kaemkate, 2012; Sirin et al., 2003). The potential for negative consequences associated with a lack of ethical understanding is cause enough to consider ethics education an essential component of the critical care nurse educational preparation.

Unfortunately, a theme emerged from the review revealing that ethics education for critical care nurse is inadequate (Bicking, 2011; Callister et al., 2009; Dierckx de Casterle et al., 2008; Hadjibalassi et al., 2012; Hough, 2008; Hughes & Dvorak, 1997; Indhrraratana & Kaemkate,

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2012; Rushton, & Stutzer, 2015; Vanlaere & Gastmans, 2007). Studies confirm that a lack of ethics-based skills development has serious implications primarily in regard to critical care nurses' experiences with moral distress. In a study by Henrich et al. (2017) examining the consequences of moral distress in ICU nurses, 50% of those sampled reported patient care as being negatively affected as a consequence of their experiences with moral distress. Sauerland, Marotta, Peinemann, Berndt, & Robichaux's (2014) mixed-method study exploring moral distress revealed that 22% of ICU nurses had left employment due to experiences with moral distress. These findings are concerning considering the negative association between quality of care and perceptions of moral distress (Choe et al., 2015; Henrich et al., 2017; Wilkinson, 1987). Furthermore, there is some discussion in the literature regarding critical care nurses' perception that their ethics education was deficient. Hughes & Dvorak (1997) conducted a non-experimental ex post facto study testing critical care nurses' ability to make ethical decisions that coincided with decisions recommended by a decision analytic model. The study results revealed that the majority of ICU nurses did not make decisions that corresponded with the recommendations of the model (Hughes & Dvorak, 1997). When shown the results, study participants felt the disparity stemmed from having received little to no ethics education (Hughes & Dvorak, 1997).

### **Lack of Agreement on Development of Ethics Education Programs**

Further analysis of the literature reveals significant dissensus and contradiction regarding the development of ethics education programs for critical care nurses. Furthermore, there is a dearth of literature suggesting any strategies that would lessen the lack of consensus or offer any concrete recommendations for program development. Grace, Robinson, Jurchak, Zollfrank, & Lee (2014) attempted to address the recommendation gap with the development of a 96-hour

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clinical ethics residency for nurses. The goals of the project were to “build clinical ethics capacity among [nurses]” and “develop, implement and evaluate” a program that was transferable to other institutions (Grace, Robinson, Jurchak, Zollfrank, & Lee, 2014). However, their educational intervention is not without its drawbacks in that it is time consuming for the participants, cost the participating facilities staffing hours, and is exclusionary in that enrollment is limited. Regardless, the impressive consensus on the necessity of ethical skill development in the critical care nurse population comes to a stark end dissolving into conflict. The dispute centers on the type of educational intervention needed and how to go about its development. Multiple and conflicting suggestions for ethical framework, educational content, and pedagogy are discussed. Mandates by accreditation agencies and recommendations by professional organizations for including ethics content in curriculums can be found in the literature; however, there are only vague interpretive statements given to guide implementation (American Association of Colleges of Nursing, 2008; AACN, 2015; NLN, 2016; NMC, 2010). It is clear there are more questions than answers regarding how to teach critical care nurses ethics.

**Disagreement on Framework.** An ethical framework is a set of moral principles or moral code used to guide decision making. Ethical frameworks proposed as the context for an ethics curriculum are numerous in the literature and can be found mostly in academic position papers. The most frequently recommended frameworks include the American Nurses Association Code of Ethics (AACN, 2015; Callister et al., 2009; Dahnke, 2014; Rushton & Stutzer, 2015), medical ethics (Nilstun et al., 2001), virtue ethics (Callister et al., 2009; Gastmans, 2002), health care ethics and bioethics (Bicking, 2011). Other articles fail to specify an ethical framework to serve as the context for curriculum development and instead use ethics as a blanket term open to interpretation (American Association of Colleges of Nursing, 2008;

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Bertonlini, 1994; Hadjibalassi et al., 2012; Hughes & Dvorak, 1997; Robichaux, 2012). Some authors even suggest that no one ethical framework is applicable to all situations (Allmark, 2005; Caldicott & Braun, 2011; Sellman, 1996), but offer no guidance for overcoming such an obvious dilemma when considering curriculum development. More puzzling, there are studies that suggest ethical decision-making models serve as the framework in program development (Hughes & Dvorak 1997; Indhraratana & Kaemkate, 2012). However, this strategy is weak for two reasons. First, it does not recognize that ethical decision-making models are developed based on a particular ethical philosophy. Second, these models assume nurses have prior knowledge of ethical principles and skill at conflict recognition. Case in point, Park (2012) critically reviewed and then integrated 20 ethical decision-making models found in the literature to produce a prescriptive model that nurses could use to assist them systematically identify ethical concerns and make decisions in daily practice. To use this decision-making model, the nurse must first identify a problem and then describe the problem in terms of conflicting principles (Park, 2012). However, the model does not specify the principles in which to frame the problem. Furthermore, the underlying assumption is that the nurse already has a clear understanding of ethical principles and how to apply them. Clearly, the framework in which to base an educational intervention on is up for debate.

**Disagreement on Content.** The content of educational interventions is also a point of debate. Rushton and Stutzer (2015) along with Robichaux (2010) state that ethics curriculum should be tailored for critical care nurses' experiences. However, they neglect to elaborate on or define what they mean by the critical care nurse experience. Other articles offer vague suggestions including teaching basic ethical principles without specifying which ethical framework's basic principles to teach (Allmark, 2005; Bertonlini, 1994; Nilstun et al., 2001;

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Sellman, 1996). This failure to clearly define ethics be it as a framework, a set of issues, or a field of study was encountered frequently in the literature and added to the difficulty in finding consensus. However, the closest to consensus on what to teach comes from the literature suggesting nurses be taught strategies for values clarification, recognition of ethical dilemmas, fostering moral agency, and ethical decision-making models (American Association of College of Nursing, 2008; Bertolini, 1994; Gastmans, 2002; Hadjibalassi et al., 2012; Hubert, 1999; Hughes & Dvorak, 1997; Robichaux, 2012). However, there is a lack of agreement on the ethical context of these suggested strategies. There appears to be conflict between supporters of action driven content that focuses on training nurses in the ethics of what should be done versus attitude driven content which focuses on training nurses in the ethics of what their character should be. Furthermore, the suggestion to use ethical decision-making models as the content for an educational intervention directly contradicts the suggestion that they serve as framework for content development.

**Disagreement on Pedagogy.** The way to present ethics educational material is the final point of debate. There is no consensus as to whether instruction should be discipline specific or multidisciplinary and no evidence to support either approach (Bertolini, 1994; Caldicott & Braun, 2011; Cloonan, Davis, & Burnett; 1999; Nilstun et al., 2001; Robichaux, 2012). Reflection both verbal and written (Callister et al., 2009; Hubert, 1999), case study (Bicking, 2011; Nilstun et al., 2001) lecture (Bicking, 2011; Rushton & Stutzer, 2015) and open debate (Allmark, 2005; Nilstun et al., 2001) are the most commonly proposed teaching methods. However, these approaches are not universally supported. Sellman (1996) suggests that a one-size-fits-all approach is inappropriate and instead supports unit specific methods of content delivery. More common in the literature is the complete lack of suggestions for pedagogy.

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Again, adding to the confusion is the suggestion that ethical decision-making models be utilized; however, not as framework nor content but as methods of content delivery (Bicking, 2011; Hughes & Dvorak, 1997). There is also a lack of agreement on who should provide ethics instruction. Nurse executive leaders, nurse educators, physicians, and trained ethicists are all offered as appropriate instructors (AACN, 2008; Bertonlini, 1994; Caldicott & Braun, 2011; Nilstun et al., 2001).

### **Barriers to Education**

Ironically, barriers to ethics education for critical care nurses are not frequently mentioned in the literature. However, when it is addressed the most frequently mentioned barriers include lack of research and evidence on critical care nurses' understanding of ethics and experiences with ethical conflicts (Hough, 2008; Hughes & Dvorak, 1997; Ruston & Stutzer, 2013; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014) and the lack of resources or institutional support for education (Gastmans, 2002).

### **Conclusion**

There is significant agreement among the papers reviewed that ethical understanding is a vital critical care nursing skill. However, current ethics educational preparation does not facilitate skill development appropriate for the critical care setting. Educational interventions that would enhance ethical skill set are lacking. There is disagreement, however, on how to develop the educational interventions that would foster skills development. Barriers to education include the need for further research and a lack of resources and institutional support for programs. Future work in ethics education for critical care nurses should focus on coming to consensus on the ethical framework, content, and pedagogy of ethics educational programs.

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### Operational Definitions

**Moral distress** – The lived experience of a perceived ethical dilemma; an acute moment of distress. It is the internal conflict an individual perceives when unavoidable circumstances prevent him or her from acting according to his or her beliefs of right and wrong (Jameton, 1984).

**Moral injury** – A lived experience that occurs when an individual participates in an action that they recognize is morally wrong but do so because the action has been justified by a legitimate body of authority (Gilligan, 2014; Shay, 2014); the chronic mental suffering an individual experiences when the inner self is demoralized (Bernstein, 2015).

**Moral resilience** – An individual's capacity to maintain, reestablish, or strengthen his or her integrity in response to ethical conflict; based on one's self-awareness of and commitment to his or her value system (Rushton, 2016).

**Moral right** – Humanity's inherent, rational understanding of what is morally correct (McInerney, 1997).

### Organizational Analysis

#### **The American Association of Critical Care Nurses**

##### **General Overview**

The American Association of Critical Care Nurses (AACN) is a non-profit professional organization for registered nurses practicing in acute and critical care settings (AACN, 2014). It was founded in 1969 as the American Association of Cardiovascular Nurses; however, changed its name in 1971 to the AACN in order to better reflect the growing diversity of the

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organization's interests (AACN, n.d.d). With over 100,000 members the association has since grown into the world's largest nursing specialty organization (AACN, 2015b).

### **Project Specific Population Overview**

Critical care nurses, the AACN's membership, is my Doctor of Nursing Practice (DNP) project's population of interest. Membership in the AACN is open to any registered nurse with an interest in the critical care specialty who is in good standing with a United States (US) based licensure agency (AACN, 2014). There are six membership options each requiring the payment of membership dues. Active, affiliate, and international-digital only membership dues are \$78 US dollars annually and emeritus, retired, and student membership dues are \$58 US dollars annually (AACN, n.d.b). Benefits of membership include free access to an online library of journal articles with accompanying continuing education units, free subscriptions to the scholarly journals *Critical Care Nurse* and the *American Journal of Critical Care*, the magazine *AACN Bold Voices*, and the electronic newsletter, *CriticalCare eNewsline* (AACN, 2014). Additional benefits that involve some cost to members include reduced rates on AACN products and services including certification test fees, critical care specific educational resources, and the peer-reviewed journal *AACN Advanced Critical Care*, reduced cost of admission to the National Teaching Institute & Critical Care Exposition, and professional liability insurance (AACN, 2014). A less tangible but just as worthy benefit of association membership is inclusion in a community of nurses who advocate for interests specific to the critical care specialty (AACN, 2014).

### **Organizational Culture**

An analysis of the association's structure, mission, and vision reveals a culture of advocacy and empowerment achieved through nursing education. The mission of the AACN is

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to create a community of critical care specialty trained nurses capable of providing excellent, evidenced-based, patient centered care by providing its members with opportunities to gain expert critical care specific knowledge (AACN, 2015a). Through its mission, the organization aims to achieve its vision of an educated and empowered critical care nursing workforce that makes a significance contribution in advocating for a patient centered health care delivery system (AACN, 2015a). To bring both the mission and vision to fruition, the AACN follows a clear strategic framework of operations guided by a 15-member elected board of directors (AACN, 2015b). Membership on this board consists of the current AACN president, the immediate past president, the president-elect, the secretary, the treasurer, the chief executive officer, and nine directors (AACN, n.d.a).

### **Funding**

The AACN has several sources of funding. In 2017, the association earned \$47, 010,398 from membership dues, educational program fees, technology-based learning fees, publications, educational resources, certification and recertification fees, investment incomes, and contributions (CliftonLarsonAllen, 2017). Over \$9,800,000 of these funds were dedicated specifically to education programs, education resources, and technology-based learning (CliftonLarsonAllen, 2017). After all expenses, net assets for the 2017 fiscal year exceeded \$128,200,000 (CliftonLarsenAllen, 2017).

### **Stakeholders**

My DNP project is specific to critical care nursing education. Therefore, project stakeholders are within the critical care nursing community and those responsible for the community's education. As an organization dedicated to increasing critical care nurses' knowledge the entire AACN can be considered a project stakeholder. However, a more focused

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stakeholder assessment suggests that the AACN's education department, its board of directors, and the AACN membership are the major project stakeholders.

### **Project Implementation Analysis**

The overall objective of my DNP project is to provide a means by which Registered Nurses can gain knowledge in health care ethics specific for practice in critical care settings. In other words, the project aims to make a contribution towards training critical care nurses. This goal very much aligns with the mission and vision of the AACN. This project also aligns with the AACN's current priority research and initiative area of working towards creating healing and humane environments (AACN, n.d.c). Therefore, the very nature of the project and the association's purpose and priorities are facilitating factors in project implementation. An additional facilitating factor is the AACN's structure. It is a well-funded and well-organized entity; once buy-in is achieved the association has the resources to support implementation. However, this also has the potential to be a major barrier to project implementation. The AACN has a very set agenda. It can be difficult to persuade an organization to take on a project that is developed outside of their predetermined strategic focus areas. In spite of this concern, I am optimistic my project will be supported. I reached out to the AACN's research department and have been in contact with Dr. Marian Altman PhD, clinical practice specialist at the AACN. Her interest in my project demonstrated by her suggestions for project implementation including my participation at the AACN's annual conference is clear evidence of support for my project's subject matter and goals.

### **Conclusion**

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While there are barriers to project implementation through the AACN, they can be overcome. The AACN is the right setting for this project. Implementation is feasible in this setting.

Chapter Three: The Project

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### Overall Goal and Project Aims

The overall goal of this DNP project was to provide a means by which Registered Nurses can gain knowledge in health care ethics specific for practice in critical care settings.

This goal was realized through three measurable aims:

- To develop a critical care specific health care ethics curriculum for Registered Nurses
- To refine and validate the curriculum content by use of an expert panel
- To implement and evaluate the ethics curriculum through a pilot program comprised of practicing critical care Registered Nurses

### Methods

#### **Aim One: Curriculum Development**

##### **Content and Content Delivery**

Curriculum content was identified by an integrative review of English language, published, peer-reviewed articles and textbooks, and grey literature. The integrative review followed the Whittimore and Knafl (2005) methodology as described below. Articles and texts used to guide curriculum development addressed one or all of the following subject matters: (1) ethical problems and dilemmas in the critical care setting, (2) health care ethics guided decision making, (3) health care ethics education delivery modalities, and (4) critical care registered nurses attitudes towards ethical decision making. Databases searched for pertinent literature included CINAHL, the Sociological Abstracts database, ERIC, the PAIS Index, and PubMed/MEDLINE. The MeSH terms and qualifiers used will include “nurses,” “nursing staff,” “critical care,” “bioethics,” “medical ethics,” “ethics,” ethical issues,” “perception”, “decision making,” “education,” “morals,” “trends,” “education,” and “curriculum.” Articles and texts

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found via database search were also hand-searched for literature that was not identified through database searches.

### **Evaluation**

A matrix was constructed to aid in organizing the final pool of articles and contained columns for title, author, journal, purpose, and article contents. These articles were coded by two independent reviewers (the primary investigator and a content expert) on a 2-point scale (2=high, 1=low) that evaluated relevance for curriculum development based on evidence of one or all of the following criteria: (1) exploration of common ethical problems and dilemmas in the critical care setting, (2) description of health care ethics guided ethical decision making in critical care, and (3) description of pedagogies in health care ethics education. Discrepancies in coding were discussed and reconciled by the two independent coders. All articles were coded and included in the final evaluation of the matrix; nothing was excluded based on this initial evaluation. Dr. Mark Lazenby PhD, advanced practice nurse and nurse ethicist, served as content expert.

A second matrix for professional nursing and critical care professional organizations' and nationally recognized nursing education organization's published standards for ethical competence was created. This matrix listed the name of professional organizations and contained columns that addressed the recommended ethics competencies, recommended teaching methods, and recommended ethics competency evaluation methods.

### **Analysis**

Analysis of the data was conducted using a comparative scaling technique called the rank-ordered approach. The data from the first matrix was ranked-ordered or ranked for importance and then grouped with data from the second matrix into categories. These categories

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were mapped from which themes were derived and agreed upon by the two reviewers. These themes then served to inform what content was included in the curriculum and the manner in which the content was taught.

The initial draft matrices produced a vast amount of content. Due to the time constraints of the project timeline, the content had to be condensed to allow for a course that could be taken during the time allotted. In order to condense the content, a modified one-step Delphi method was employed (Helmer-Hirschberg, 1967). Invitations to participate in a Delphi panel were sent via email to fourteen potential panelists asking two questions. The panelists were asked: (1) what should critical care nurses know in order to successfully navigate the ethical climate of the critical care units, and (2) what training should critical care nurses receive in order to gain this knowledge? Seven panelists accepted the invitation to participate and their responses were used to streamline the content into a curriculum that was able to be completed in the time allowed.

### **Aim Two: Refining and Validating the Curriculum**

#### **Procedure**

Refinement and validation of the curriculum was completed by a five-member expert panel. Selection of these experts was based on their prominence in the health care ethics literature and/or nursing ethics literature, their experience in developing and teaching university level health care related ethics, experience in critical care nursing. At least one panelist had experience specific to curriculum development. See Appendix A for the list of panelists. Potential panelists were contacted via email or phone call requesting their participation and once they agreed to participate an email attachment was provided detailing how the draft curriculum was developed. The process of curriculum review was also included in this second correspondence.

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Upon receiving the draft curriculum, panelists independently reviewed and rated its content. Each panelist received an electronically distributed rating guide where they were instructed to rate each identified theme's importance (1=Yes, 0=No) to critical care nursing knowledge, and each identified theme's relevance (1=Yes, 0=No) to each of the following categories: (1) professional association recommendations, (2) nationally recognized nursing education organization recommendations, and (3) critical care nursing community recommendations. Whether or not the item as written clearly expressed the idea, or its clarity was also rated (1=Yes, 0=No). When a panelist assigned a split score for importance and relevance (meaning a 1=Yes and a 0=No) then the panelist was asked to submit his or her suggestions on reconciling the disparity on the rating guide. When a panelist rated an item as lacking clarity, he or she was asked to submit suggestions for rewording on the rating guide.

Each panelist's review was collected and a percentage of agreement calculated. Identified themes regarding content with more than 78% agreement as important and relevant were included in the curriculum. In addition, identified themes regarding teaching methods with more than 78% agreement as important and relevant were used to frame how the included content was presented to potential users of the curriculum.

The validated and refined content was then formatted into a web-based curriculum containing text, audio, and visuals. This format was chosen as it has the potential to reach the largest critical care nursing audience and is the preferred curriculum delivery method of the AACN. Once formatting was complete, the web-based curriculum was uploaded to the secure online learning platform Canvas.

### **Analysis**

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The data collected from the rating guide was analyzed using percentages. Each theme score was tallied by category, divided by 5 (the number of panelists), and multiplied by 100 to derive percentage agreement. See Appendix B for the rating guide and guidelines.

### **Aim Three: Implementation and Evaluation**

#### **Procedure**

Implementation took place with the assistance of a critical care professional association. The professional associations' education department was contacted by email with a link to the secure online curriculum on the online learning platform Canvas. Eligible practicing critical care registered nurses were then solicited from the association's membership for pilot testing of the refined and validated curriculum. Solicitation of the critical care nurses was based on the following eligibility criteria: (1) have access to a critical care professional organization's education resources, (2) have a minimum of one-year critical care nursing experience, (3) have had no prior critical care specific ethics training, and (4) have no prior interaction with the investigator (JR). Recruited critical care nurses were given a specified time frame in which to complete the course. Pilot testing took place in the 2019-2020 academic year with the goal of ascertaining feasibility and acceptability in increasing critical care registered nurses' skills in ethics needed for practice in critical care settings.

#### **Analysis**

An analysis of the curriculum's acceptability was conducted through course evaluation. Upon completion of the course, the critical care nurses were given a course evaluation consisting of questions with answers rated on a Likert scale. The course evaluation was a modified version of an evaluation tool used in Artino's (2008) study examining the effectiveness of online training. All answers to the course evaluation were individually analyzed to determine if the

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majority of the respondents (50% or greater) believed the course: (1) increases the critical care nurse's knowledge of health care ethics, (2) if the course delivery method was appropriate for the content presented, (3) if the content was valuable to their practice, and (4) their overall satisfaction with the course. An analysis of the curriculum's feasibility was conducted by comparing: (1) the number of eligible registered nurses contacted to the number of those who consented to participate, (2) the number of participants who completed the curriculum to the number of participants that started it. A ratio of 1:2 or greater (50% or greater) of both comparison ratios was confirmation of feasibility.

### Analytical Plan

Formative and summative assessment of each individual aim and the entire project were conducted. Each aim had its own benchmark indicating accomplishment. Meeting all three aims was confirmation of DNP project implementation success.

### **Analysis of Aim One**

The benchmark for the accomplishment of aim one was the completion of the integrative review of the literature evidenced by the creation of the two matrixes detailed above. The final deliverable for this aim was an electronic document containing the curriculum's content and the rating guide ready to be electronically submitted to the expert panel.

### **Analysis of Aim Two**

The benchmark for aim two was a refined and validated web-based health care ethics curriculum ready for implementation. Once the expert panel received and reviewed the curriculum, and an analysis of the rating guide was conducted as detailed above, the validated and refined curriculum was formatted into a web-based curriculum. The final deliverable for this

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aim was a web-based health care ethics curriculum for critical care nurses uploaded on the secure online learning platform Canvas.

### **Analysis of Aim Three**

The benchmark for aim three was a manuscript reporting on the results of the pilot program. Participants were recruited to participate in the pilot program and data gathered and analyzed as detailed above. The final deliverable for aim three was project report summary detailing the development of the pilot, its results, and implications.

### **Implications**

The results of this project will add to the existing body of work on critical care nurses' understanding of health care ethics, their readiness to apply health care ethics in critical care settings, and methods in which to train critical care nurses in ethics. Furthermore, this project has the potential to lead to new inquiries on the impact ethics education has on critical care nurses; if feasible and acceptable, the curriculum can be utilized in a full-scale trial to test its efficacy in reducing the demoralization critical care nurses experience. If shown to reduce the incidence of demoralization, a long-term goal would be formal adoption of the curriculum by the AACN as a component of critical care nurse education. Through education this DNP project aims to strengthen the ethical voice of the critical care nurse and optimize his or her contribution in creating and maintaining ethical critical care environments and health care systems.

### **Human Subjects**

This project did not require full Institutional Review Board (IRB) approval; instead, an application for exemption was submitted. There were no identifiers collected with the data that was gathered. The anonymity of the participants, no use of protective health information, and the instructional nature of the project qualified this project for an IRB exemption category two.

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## Timeline

| <b>Objective</b>   | <b>Timeframe</b>   |
|--|--|
| Institutional Review Board Application                                   | Submission 2000023986 –<br>Exemption approved                |
| Curriculum Development   | Fall 2018– February 2019<br><i>Benchmark Aim One due</i>     |
| Refinement and Validation of Curriculum                                  | February 2019 – April 2019                                   |
| Web-based Format Development   | May 2019 – August 2019<br><i>Benchmark Aim Two due</i>       |
| Pilot Program Implementation   | September 2019 – December 2019                               |
| Analysis of the Data   | January 2020 – February 2020                                 |
| Preparation of Project Summary of Findings<br>and Submission to Database | February 2020 – April 2020<br><i>Benchmark Aim Three Due</i> |

## Leadership Immersion

Implementation of my Doctor of Nursing Practice (DNP) project was not site specific. Instead it was problem and population specific. Therefore, leadership immersion and its objectives were centered on activities pertaining to the problem the project is addressing, and the population of interest: health care ethics education, and the critical care nursing community.

Immersion activities related to education in health care ethics application focused on participating in philosophical argument with experts in the field of ethics. Collaboration and debate on the curriculum content occurred during curriculum development with the content expert and with each member of the expert panel during the curriculum refining and validating process. Both collaborations are detailed in my project proposal. A refined and validated curriculum serves as evidence of meeting this portion of the immersion objective. In addition, seeking out additional experts and learning the skill of ethical dialogue beyond the scope of my project was valuable. There are several ethics conferences that take place annually where the most published and respected nurse ethicists gather to disseminate their work and debate. Part of leadership immersion was to attend some of these conferences. Although I did not anticipate

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presenting my project at these conferences during my immersion, I intended to submit an abstract so that I may present my project results at a later date.

Population specific leadership immersion activities focused on collaborating with the AACN. Implementing the pilot required coordination between myself, my advisor, and the AACN research department. Successful project implementation served as evidence of meeting this portion of the immersion objective. In addition, a grant proposal requesting funding for this project was submitted to the AACN research department. If I had been awarded this grant, I would have been required to present my DNP project at the AACN's annual conference, the National Teaching Institute (NTI). While I was not awarded the grant, I was invited by the AACN's research department to participate in NTI and submitted an abstract so that my DNP project could be included in NTI activities. Both opportunities provided a leadership immersion experience with the leaders of the critical care nursing community.

Chapter Four: Results and Implications

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### Aim One Results: Curriculum Development

Curriculum development took place between November 2018 through May 2019. The curriculum's content was drafted as outlined in chapter three of the project proposal. The initial draft produced a vast amount of material. Due to the time constraints of the project timeline, the material had to be condensed to allow for a course that could be taken during the time allotted. In order to condense the content, a modified one-step Delphi method was employed (Helmer-Hirschberg, 1967). Invitations to participate in a Delphi panel were sent via email to fourteen potential panelists asking two questions. The panelists were asked: (1) what should critical care nurses know in order to successfully navigate the ethical climate of the critical care units, and (2) what training should critical care nurses receive in order to gain this knowledge? Seven panelists consented to participate in the panel by responding with their answers. See Appendix C for a list of the modified Delphi panelists.

The Delphi responses were reviewed by two independent reviewers. Twenty-three content items emerged that were then grouped into five themes. These themes and items were used to edit and organize the curriculum content. See Appendix B to view the five themes and 23 content items. Once the content was edited and organized by theme and item the draft curriculum was formatted into 23 separate podcast written scripts. These podcasts scripts composed the first draft of the health care ethics course.

### Aim Two Results: Refining and Validating the Curriculum

Refinement and validation of the curriculum was conducted by a five-member expert panel. Starting in May 2019, a total of 11 invitations were sent to various experts as outlined in Chapter 3 of the project proposal. By the end of June 2019, the five-member expert panel was assembled. All members of the panel were Registered Nurses; four had expertise in ethics; four

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were Doctors of Philosophy; three specialized in critical care; and one was a Doctor of Jurisprudence. See appendix A for a list of the experts and their qualifying criteria.

The 23 podcast scripts of the draft curriculum along with the supporting references were sent to the five experts via email. The panelists were also sent a rating guide and guidelines as outlined in Chapter 2 of the project proposal. See Appendix B for the rating guide and guidelines. Lastly, each panelist was asked to rate the course format and teaching method (i.e., online, self-paced, self-reflection). The refinement and validation process took place from July 2019 to September 2019. This process included completion of the rating guide by each of the panelists and correspondence with the panelists when a content item required clarification. Once all the rating guides were completed a percentage of agreement was calculated for each content item. Of the 23 content items included in the draft curriculum, 18 items rated as important and relevant with greater than 78% agreement. Two items that did not have greater than 78% agreement were excluded from the curriculum. The teaching method proposed to deliver the content rated as 100% agreement. These refined and validated 18 podcast scripts made up the second, refined, and validated draft of the health care ethics course.

### Aim Three Results: Implementation and Evaluation of the Curriculum

#### **Implementation**

In order to go forward with implementation of the refined and validated curriculum, the final scripts had to be placed into an online compatible format. Formatting began by turning the scripts into videos with voiceover. Interviews with five critical care nurses exploring what they do as a form of self-expression, the personal values that the self-expression demonstrates, and how they see these values their work were also filmed. This process took place from October 2019 to December 2019. One videographer, two video editors, one narrator or script reader, and

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seven Registered Nurses participated in the audio recording, filming, and editing of the content containing videos. All the Registered Nurses were volunteers; the videographer and video editors were given an honorarium. Once all the videos with voiceover and interviews were completed, transcripts of the audio were made. The final online curriculum included the 18 content videos with voiceover, the interviews with five Registered Nurses, and transcripts for all the audio. Also included and delivered in both video and written format was an introduction to the course, an explanation of course expectations, and syllabus.

The final curriculum content was then loaded onto Yale School of Nursing's password-secured the online learning platform Canvas Instructure. An instructional technology specialist reviewed the final course layout in Canvas. The end result was an online course composed of five modules. Each module addressed one of the five validated themes and opened with one of the interviews. The videos within each module addressed a specific content item as outlined in the framework provided by the refined and validated rating guide. Each module ended with a discussion board in which the participant were asked to think about the content and then post in the board his or her thoughts, feelings, or critiques of the content using any modality of self-expression they were comfortable with (e.g. song lyrics, diary entry, blog post, a picture of a piece of art, personal photo or meme). They were instructed that the modality did not need to be consistent throughout the course and that these posts would be anonymous. The last module did not have any video; it was an audio podcast and transcript. This module asked the participants to look back at each reflection posting in the five discussion boards and draw out at least one theme from their submissions. Participants were asked to reflect on the theme(s) identified and explore how the theme(s) informed their value system, or personal ethic. This exercise was key to the overarching goal of the course: assisting the participant in developing an understanding of what

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he or she brings to the ethical milieu of the critical care environment. The final module thanked the participants for their time, asked them to complete an online course evaluation. The course evaluation was a modified version of Dr. Anthony Artino's survey as outlined in chapter three of the project proposal. The course evaluation was built in the experience management platform Qualtrics and the link to the survey placed as the final activity in the course. See Appendix E for the course evaluation.

The final step in implementation was to have the link to Canvas and course enrollment placed on the AACN's website. The link, a copy of the Institutional Review Board exemption, and a participant-informed consent document was submitted to the AACN in December 2019. After review of all the documents, the AACN posted an invitation to participate in the pilot along with the link to enroll in the course. The pilot was open for enrollment the first week of January 2020. Enrollment in the pilot ended the last week in February 2020.

### **Evaluation**

#### **Feasibility**

The original plan for analysis of the curriculum's feasibility was to be conducted by comparing: (1) the number of eligible registered nurses contacted to the number of those who consented to participate, (2) the number of participants who completed the curriculum to the number of participants that started it. A ratio of 1:2 or greater (50% or greater) of both comparison ratios would confirm feasibility. However, recent changes in the AACN's ability to track the number of members who access the webpage made tracking this data impossible. Therefore, for the purposes of the project, feasibility will be limited to an analysis of the number of participants who completed the curriculum to the number who started it with a ratio of 1:2 or greater confirming feasibility.

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During the enrollment period 27 eligible registered nurses consented to participate and all 27 began the curriculum. At the close of the pilot, four had completed the program evidenced by completion of the course evaluation. This indicates that 14.8% of the participants completed the pilot during the time allotted.

### Acceptability

An analysis of the curriculum's acceptability was conducted through the course evaluation. All answers to the four course evaluation were individually analyzed to determine if the majority of the respondents (50% or greater) believe the course: (1) increases the critical care nurse's knowledge of health care ethics, (2) if the course delivery method was appropriate for the content presented, (3) if the content was valuable to their practice, and (4) their overall satisfaction with the course. See the table below for results of the analysis. The maximum column indicates the maximum score possible and the minimum column indicates the minimum score received. These results indicate that the majority of the respondents believed the course: (1) increased the critical care nurse's knowledge of health care ethics, (2) was delivered in a method appropriate for the content presented, (3) that the content was valuable to their practice, and (4) were overall satisfied with the course.

**Table 1**

#### *Acceptability Results of Health Care Ethics Curriculum*

Q1 - The following statements relate to your opinions regarding the value of this course.

| # | Field   | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|---|---------|---------|------|---------------|----------|-------|
| 1 | This course provided a great deal of practical information.                         | 6.00    | 7.00    | 6.75 | 0.43          | 0.19     | 4     |
| 2 | I was very interested in the content of this course.                                | 6.00    | 7.00    | 6.50 | 0.50          | 0.25     | 4     |
| 3 | It was important to me to learn the material in this course.                        | 5.00    | 7.00    | 6.25 | 0.83          | 0.69     | 4     |
| 4 | The knowledge I gained by taking this course can be applied to my nursing practice. | 6.00    | 7.00    | 6.75 | 0.43          | 0.19     | 4     |

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| # | completely disagree | mostly disagree | tend to disagree | neutral | tend to agree | mostly agree | completely agree | Total |        |   |        |   |        |   |   |
|---|---------------------|-----------------|------------------|---------|---------------|--------------|------------------|-------|--------|---|--------|---|--------|---|---|
| 1 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 0.00%  | 0 | 25.00% | 1 | 75.00% | 3 | 4 |
| 2 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 0.00%  | 0 | 50.00% | 2 | 50.00% | 2 | 4 |
| 3 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1 | 25.00% | 1 | 50.00% | 2 | 4 |
| 4 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 0.00%  | 0 | 25.00% | 1 | 75.00% | 3 | 4 |

**Q2 - The following statements relate to how much the course increased your knowledge of health care ethics.**

| # | Field   | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|---|---------|---------|------|---------------|----------|-------|
| 1 | This course increased my understanding of the principles of health care ethics.                       | 5.00    | 7.00    | 6.25 | 0.83          | 0.69     | 4     |
| 2 | This course increased my understanding of moral distress, moral resilience, and moral accountability. | 5.00    | 7.00    | 6.25 | 0.83          | 0.69     | 4     |
| 3 | This course increased my understanding of how I make ethical decisions.                               | 6.00    | 7.00    | 6.50 | 0.50          | 0.25     | 4     |
| 4 | This course increased my understanding of the most common ethical issues in critical care.            | 6.00    | 7.00    | 6.50 | 0.50          | 0.25     | 4     |

| # | completely disagree | mostly disagree | tend to disagree | neutral | tend to agree | mostly agree | completely agree | Total |        |   |        |   |        |   |   |
|---|---------------------|-----------------|------------------|---------|---------------|--------------|------------------|-------|--------|---|--------|---|--------|---|---|
| 1 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1 | 25.00% | 1 | 50.00% | 2 | 4 |
| 2 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1 | 25.00% | 1 | 50.00% | 2 | 4 |
| 3 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 0.00%  | 0 | 50.00% | 2 | 50.00% | 2 | 4 |
| 4 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 0.00%  | 0 | 50.00% | 2 | 50.00% | 2 | 4 |

**Q3 - The following statements relate to your belief that the course delivery method was appropriate for the content presented.**

| # | Field  | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|--|---------|---------|------|---------------|----------|-------|
| 1 | Even in the face of technical difficulties, I was able to learn the material presented in this course. | 4.00    | 7.00    | 6.00 | 1.22          | 1.50     | 4     |
| 2 | I am confident I can learn without the presence of an instructor to assist me.                         | 5.00    | 7.00    | 6.00 | 0.71          | 0.50     | 4     |
| 3 | I am confident I can do an outstanding job on the activities in a self-paced, online course.           | 5.00    | 7.00    | 6.00 | 0.71          | 0.50     | 4     |
| 4 | I am certain I can understand the most difficult material presented in a self-paced, online course.    | 5.00    | 7.00    | 6.00 | 0.71          | 0.50     | 4     |

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| 5 | Even with distractions, I am confident I can learn material presented online. |                 |                  |         |               |              | 5.00             | 7.00  | 6.00   | 0.71 | 0.50   | 4 |        |   |   |
|---|---|-----------------|------------------|---------|---------------|--------------|------------------|-------|--------|------|--------|---|--------|---|---|
| # | completely disagree   | mostly disagree | tend to disagree | neutral | tend to agree | mostly agree | completely agree | Total |        |      |        |   |        |   |   |
| 1 | 0.00%   | 0               | 0.00%            | 0       | 0.00%         | 0            | 25.00%           | 1     | 0.00%  | 0    | 25.00% | 1 | 50.00% | 2 | 4 |
| 2 | 0.00%   | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1    | 50.00% | 2 | 25.00% | 1 | 4 |
| 3 | 0.00%   | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1    | 50.00% | 2 | 25.00% | 1 | 4 |
| 4 | 0.00%   | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1    | 50.00% | 2 | 25.00% | 1 | 4 |
| 5 | 0.00%   | 0               | 0.00%            | 0       | 0.00%         | 0            | 0.00%            | 0     | 25.00% | 1    | 50.00% | 2 | 25.00% | 1 | 4 |

**Q4 - The following statements relate to your overall satisfaction with the course**

| # | Field  | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|--|---------|---------|------|---------------|----------|-------|
| 1 | Overall, I was satisfied with my online learning experience.                       | 6.00    | 7.00    | 6.50 | 0.50          | 0.25     | 4     |
| 2 | This online course met my needs as a learner.                                      | 6.00    | 7.00    | 6.50 | 0.50          | 0.25     | 4     |
| 3 | I would recommend this online course to a friend who needed to learn the material. | 6.00    | 7.00    | 6.75 | 0.43          | 0.19     | 4     |

| # | completely disagree | mostly disagree | tend to disagree | neutral | tend to agree | mostly agree | completely agree | Total |        |   |   |
|---|---------------------|-----------------|------------------|---------|---------------|--------------|------------------|-------|--------|---|---|
| 1 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 50.00%           | 2     | 50.00% | 2 | 4 |
| 2 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 50.00%           | 2     | 50.00% | 2 | 4 |
| 3 | 0.00%               | 0               | 0.00%            | 0       | 0.00%         | 0            | 25.00%           | 1     | 75.00% | 3 | 4 |

## Implications

The preliminary results indicate that using a professional organization to facilitate a self-paced, online program may not be the best modality for teaching health care ethics to critical care nurses. The limited feasibility analysis reveals only 14.8% of the participants who enrolled completed the course. This could be the case for several reasons. The lack of an instructor's

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presence could have contributed to the low completion rate. Traditional instruction includes the presence of an instructor encouraging participation and completion of tasks. This pilot was completely self-paced; there was no interaction with an instructor at all. It is possible that more participants would have completed the course if they had been encouraged to, or had incentive from their work settings to do so. The online format could have contributed to the low rates of completion. The lack of face-to-face interaction with an instructor could have also contributed to the participants starting but not finishing the course. Lastly, the two-month time period the participants were given to complete the course may not have been enough time for completion of a self-paced program. Conversely, it could have been too long and thus they forgot about it. Extending the length of time the participant had to complete the course or including incentives to complete in a discreet time period could increase completion rates.

Chapter Five: Dissemination

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Dissemination of this project has exceeded expectations. The initial project plan was to end the pilot and have all data gathered, analyzed, and reported in the Spring of 2020. This would allow for a two-month long pilot period. A project summary report was to be submitted along with a manuscript for publication. For the purposes of this DNP project, the data generated thus far will be analyzed and reported in this project summary report. However, the AACN has extended an invitation to continue the pilot to allow for it to be included in the National Teaching Institute and Critical Care Exposition (NTI) research table. Therefore, a new plan to continue enrollment in the pilot through the spring and into early summer 2020 has been implemented. Results from the pilot's entire enrollment time will be included in a manuscript submitted for publication in late summer 2020.

This new plan will have a positive impact in two respects. First, it will greatly increase the dissemination of this work. Over 7,000 critical care nurses attend NTI every year (AACN, 2019). Participation in the NTI research table will provide an opportunity to directly invite this large number of eligible critical care nurses to participate in the pilot and also assist them with enrollment. Furthermore, these critical care nurses will be able to take information on the pilot along with instructions on how to participate in the pilot back to critical care nursing units located all over the country. Essentially, attending NTI and promoting the pilot program will promote awareness of both the pilot's health care ethics course and of the state of health care ethics education in the critical care nursing community. Secondly, it will allow for more complete data collection in terms of feasibility. Currently, the AACN is not able to report how many critical care nurses access the webpage hosting the link the pilot program. To overcome this obstacle, the AACN suggested using the number of critical care nurses invited or contacted to enroll at NTI versus the number who consent to participate as a ratio evaluating feasibility.

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Allowing for this opportunity for more data collection will only add strength to the future results analysis that will be reported. The stronger the data collection and analysis the higher the chance a manuscript will reach publication and the widest audience.

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## Appendix A: Expert Panel

Dr. Amy M. Haddad, PhD, RN

Critical care nurse ethicist and educator; Director for the Center for Health Policy & Ethics at Creighton University (retired)

Dr. Douglas Olsen, PhD, RN

Nurse ethicist and educator; Assistant Professor of Nursing and Medicine at Michigan State University; served as nurse ethicist at the National Center for Ethics in Health care, Veterans Administration

Dr. Catherine E. Robichaux, PhD, RN, Alumna CCRN

Critical Care nurse ethicist and educator; Assistant Professor, Adjunct at The University of Texas Health Science Center and Nursing Ethics Council faculty advisor; member of the Steering Committee to review the 2015 *Nursing Code of Ethics with Interpretive Statements*; member of the ANA Center for Human Rights and Ethics Advisory Board

Liz Stokes, JD, MA, RN

Nurse ethicist and nurse attorney; Director of the American Nurses Association Center for Ethics and Human Rights; American Society for Bioethics and Humanities Nurse Affinity Group board member

Dr. S. Brian Widmar PhD, RN, ACNP-BC, CCRN, CNE, FAANP

Critical care nurse educator; certified Acute Care Nurse Practitioner with a clinical background in cardiothoracic critical care, Director of the Adult and Gerontology Acute Care Nurse Practitioner program at Vanderbilt University School of Nursing

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Appendix B: Rating Guide and Guidelines

| Theme   | Importance<br>Is the theme important knowledge the critical care nurse should have? | Relevance  |   |   | Clarity                       |                            |
|---|---|--|---|---|-------------------------------|----------------------------|
|   |   | Is the theme relevant to professional association recommendations? | Is the theme relevant to recommendations regarding nursing education made by nationally recognized nursing education organizations? | Is the theme relevant to practice guidelines made by critical care nursing organizations? | Is the theme clearly written? |                            |
|   | Importance<br>(1=Yes, 0=No)   | Relevance<br>(1=Yes, 0=No)   | Relevance<br>(1=Yes, 0=No)  | Relevance<br>(1=Yes, 0=No)  | Clarity<br>(1=Yes, 0=No)      | Suggestions for rewording? |
| <b>The basics</b>                                 |   |  |   |   |                               |                            |
| The four principles                               |   |  |   |   |                               |                            |
| Hospital ethics                                   |   |  |   |   |                               |                            |
| Impact of religious directives                    |   |  |   |   |                               |                            |
| <b>What the CCRN encounters</b>                   |   |  |   |   |                               |                            |
| Complexity of ICU environment                     |   |  |   |   |                               |                            |
| Interdisciplinary conflict                        |   |  |   |   |                               |                            |
| Our common humanity                               |   |  |   |   |                               |                            |
| Respect for boundaries                            |   |  |   |   |                               |                            |
| <b>What the CCRN experiences</b>                  |   |  |   |   |                               |                            |
| Moral injury                                      |   |  |   |   |                               |                            |
| Moral distress                                    |   |  |   |   |                               |                            |
| Moral resilience                                  |   |  |   |   |                               |                            |
| Moral accountability                              |   |  |   |   |                               |                            |
| <b>Navigating the complex ICU environment</b>     |   |  |   |   |                               |                            |
| Ethical decision-making models                    |   |  |   |   |                               |                            |
| Identifying ethical dilemmas                      |   |  |   |   |                               |                            |
| Acting on ethics-based decisions                  |   |  |   |   |                               |                            |
| Conflict resolution techniques                    |   |  |   |   |                               |                            |
| Novice to expert                                  |   |  |   |   |                               |                            |
| Trial and error                                   |   |  |   |   |                               |                            |
| <b>Common ethically challenging topics in ICU</b> |   |  |   |   |                               |                            |
| End of life                                       |   |  |   |   |                               |                            |
| Patient rights                                    |   |  |   |   |                               |                            |
| Brain death                                       |   |  |   |   |                               |                            |
| Palliative services                               |   |  |   |   |                               |                            |
| Advance directives                                |   |  |   |   |                               |                            |
| DNR principles                                    |   |  |   |   |                               |                            |

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**Nursing Education Organization Recommendations****\*The Nine Essentials**

\* Taken from *The Essentials of Baccalaureate Education for Professional Nursing Practice* - American Association of Colleges of Nursing, October 20, 2008

**Essential I: Liberal Education for Baccalaureate Generalist Nursing Practice**

- A solid base in liberal education provides the cornerstone for the practice and education of nurses.

**Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety**

- Knowledge and skills in leadership, quality improvement, and patient safety are necessary to provide high quality health care.

**Essential III: Scholarship for Evidence Based Practice**

- Professional nursing practice is grounded in the translation of current evidence into one's practice.

**Essential IV: Information Management and Application of Patient Care Technology**

- Knowledge and skills in information management and patient care technology are critical in the delivery of quality patient care.

**Essential V: Health Care Policy, Finance, and Regulatory Environments**

- Healthcare policies, including financial and regulatory, directly and indirectly influences the nature and functioning of the healthcare system and thereby are important considerations in professional nursing practice.

**Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes**

- Communication and collaboration among healthcare professionals are critical to delivering high quality and safe patient care.

**Essential VII: Clinical Prevention and Population Health**

- Health promotion and disease prevention at the individual and population level are necessary to improve population health and are important components of baccalaureate generalist nursing practice.

**Essential VIII: Professionalism and Professional Values**

- Professionalism and the inherent values of altruism, autonomy, human dignity, integrity, and social justice are fundamental to the discipline of nursing.

**Essential IX: Baccalaureate Generalist Nursing Practice**

- The baccalaureate-graduate nurse is prepared to practice with patients, including individuals, families, groups, communities, and populations across the lifespan and across the continuum of healthcare environments.
- The baccalaureate graduate understands and respects the variations of care, the increased complexity and increased use of healthcare resources inherent in caring for patients.

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**Critical Care Nursing Organization Practice Guidelines****\*Scope of Practice: Ethics**

\*Taken from the *AACN scope and standards for acute and critical care nursing practice* – American Association of Critical-Care Nurses, 2015

“Acute and critical care nurses engage in ethical practice and base decisions and actions upon their commitment to patients and families, consistent with the ANA *Code of Ethics for Nurses with Interpretive Statements* and the AACN Values. The acute and critical care nurse acknowledges the dignity, autonomy, cultural beliefs, and privacy and confidentiality of patients and their families. In addition, the acute and critical care nurse advocates for the patient and family in care decisions, including implementation of palliative and end-of-life care supporting the goal of patient- and family-centered care. The obligation of advocacy continues into the realm of research, whether in the conduct or facilitation of research involving the patient, family, or members of the interprofessional team. The nurses caring for acutely and critically ill patients also have the ethical obligation to maintain patient safety by reporting any unsafe conduct by members of the interprofessional team. This applies not only to specific actions, but also to the overall maintenance of professional competence and personal health. It is essential that nurses and all members of the team caring for acutely and critically ill patients be vigilant and alert to monitor and respond appropriately to changes in patient health or illness. When moral distress is evident within the work environment, the nurse caring for acutely and critically ill patients must seek to determine the cause and to facilitate resolution. Actions such as bullying among peers or poor communication and collaboration among members of the team must be addressed to ensure the health of the work environment and the safety of the patient.” (AACN, 2015, pg. 10-11).

**Standards of Practice 5: Ethics**

The nurse’s decisions and actions are carried out in an ethical manner in all areas of practice.

Competencies:

- Practices as guided by the ANA *Code of Ethics for Nurses with Interpretive Statements*, the AACN Values, and ethical principles
- Promotes ethical accountability and integrity in relationships, organizational decisions, and stewardship of resources
- Protects patient confidentiality within legal and regulatory parameters
- Advocates for the concerns of patients, their families, and the community
- Delivers care in a nonjudgmental and nondiscriminatory manner that meets the diverse needs of the patient, family, and community
- Maintains patient autonomy, dignity, values, beliefs, and rights at all times
- Uses available resources in formulating ethical decisions
- Demonstrates a commitment to self-care and self-advocacy
- Reports unethical, illegal, incompetent, or impaired practices
- Assists patient and family in self-determination and informed decision-making
- Maintains a therapeutic and professional nurse/patient relationship within appropriate role boundaries

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- Contributes to resolving ethical issues involving the patient, family, and interprofessional team
- Questions healthcare practice when necessary for safety and quality improvement
- Collaborates with the interprofessional team to promote palliative care or end-of-life discussions, decisions, and care

### **Strategies for Integration: Ethics**

Clinical decision-making and nursing actions must be based on sound ethical principles.

Strategies that

reflect integration of this standard:

- Ensures that decisions are patient-focused and based on the *Code of Ethics for Nurses with Interpretive Statements*
- Questions motivation for changing care practices and ensures changes are patient-centered and will benefit the patient and family directly
- Ensures patient-specific information or identifiers are kept confidential after participating in morbidity and mortality rounds, root cause analyses, or case reviews
- Advocates in the care of patients and families to ensure that their rights and needs are always considered and given priority in care decisions
- Allows cultural practices to be continued at the bedside and ensures the practice will benefit the patient
- Asks for ethics committee consultation to assist the interprofessional team in developing plans to address ethical dilemmas
- Promotes understanding of advance directives with peers, patients, patient families, and community
- Participates as a member of the organizational ethics committee
- Maintains self-care and manages personal stress
- Maintains self-awareness when participating in dialogue regarding ethical dilemmas, taking care to not insert own personal beliefs into the discussion
- Reports illegal, incompetent, or impaired practices to appropriate personnel

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**Professional Nursing Association Recommendations****\*The Nine Provisions**

\*Taken from the American Nurses Association *Code of Ethics for Nurses*, 2015

**Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth and unique attributes of every person

**Provision 2:** The nurse's primary commitment is to the patient, whether an individual, family, group, community or population.

**Provision 3:** The nurse promotes, advocates for, and protects the rights, health, and safety, of the patient.

**Provision 4:** The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

**Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

**Provision 6:** The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

**Provision 7:** The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

**Provision 8:** The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

**Provision 9:** The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

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## Appendix C: Modified One-Step Delphi Panelists

Nathan Ashby MD

Board certified Critical Care physician for 12 years; Assistant Professor of Clinical Anesthesiology Vanderbilt Medical School and Adjunct professor of Nursing Vanderbilt School of Nursing

Dennis Gonzalez PhD

Vice President of Mission and Ethics CHRISTUS Santa Rosa Health System

Chris Jacobson RN

Critical Care staff nurse; two years critical care nursing experience in one setting

Margaret Jones BCC, PCHAC

Director of Pastoral Care CHRISTUS Santa Rosa Health System; member of the 85th Texas Legislature Palliative Care Interdisciplinary Advisory Council

Lyndsay Mills RN, CCRN

Critical Care staff nurse; eight years of critical care nursing experience in units of various sizes all over the United States

Aideen Savage RN

Critical Care charge nurse; 20 years of critical care nursing experience in seven different countries including the Royal Australian Airforce

Leslie Schubert MSN, RN, CCRN-E

Critical Care Director of Nursing and Ethics committee member; 20 years of critical care nursing experience

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### Appendix D: Online Course Curriculum Transcripts

#### **Video 1: Welcome**

*Andrew:*

Hello, welcome to the course Health Care Ethics for critical care nurses. I'm Andrew, your host and course instructor. In the videos that follow, I'm going to be guiding you along a journey of self-reflection and self-discovery as you learn about the ethics of the critical care area.

You won't be traveling on this journey alone. You will be going on this journey with three critical care nurses: Rachel, Allie, and Melissa. They will be listening by podcast and sharing their personal reflections with you as they make their way through the course content.

Now, I invite you to find a quiet comfortable spot and begin the course. Go to the next video for an explanation on how you will access the course content.

---

#### **Video 2: Explanation of the learning platform**

*Andrew:*

Hello again. In this video I'll be telling you how to access the course content and progress through the course.

All the materials you need to complete this course can be found on the Canvas website. The syllabus, should you want to take a look at it, can all be accessed from the menu on the left of your screen. The course content which includes videos, video transcripts, and references is broken up into modules and can be accessed by clicking on the module's menu tab.

To progress through the course, start with the course content in module 1. Watch the videos and participate in the reflection activity. I'll talk more about the reflection activity later. When you're done with the activity, move on to the next module. When you've completed all the content modules, you'll end the course by completing the module titled course wrap up.

Take your time, and enjoy the learning experience. This course is meant to make you think, but not to make you stress. Go to the next video for an explanation of the course expectations.

---

#### **Video 3: Explanation of the Course**

*Andrew:*

Before I tell you what the course objectives are and what will be expected of you as you move through the course, let me take a minute to remove any preconceptions. There won't be any multiple choice or fill in the blank questions to answer. No quizzes, or essay questions. This course is not intended to test your recall. Instead, after each module you will be asked to think about what you have learned, relate the content to your everyday life and your nursing practice, and then share your reflections on a discussion board.

These reflections can take any form you wish. They can be a journal entry, a line of poetry or song lyric, or a meme...anything that expresses your thoughts on what you just learned. Be creative, the point is self-expression. And rest assured, these reflections will be kept confidential and treated respectfully. You will be posting anonymously and they will be in no way graded or

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judged. These discussion boards are simply a repository, a convenient way to house your thoughts and feelings during the course. You're going to need these reflections later.

The objective of this approach is to make this content personal and relatable. The goal is to help you discover what you value and the ethic that guides you and your nursing practice while you learn about the ethical environment of the critical care area.

To help you better understand what these reflections may look like, each module begins with a video interview. In these interviews you will see real critical care nurses sharing their insights on what is important to them and how that is reflected in their practice.

At the end of the course, I'm going to ask you to do a small activity with the collection of reflections you've posted and also a complete a short course evaluation.

Now, I think you're ready to begin. Go to the menu on the left side of your screen and start your journey. The course content begins with module 1.

---

### **Module One: The Basics**

#### **Video 4 – Part 1: The Principles**

##### **Featuring Rachel**

*Andrew:*

Before we get into the ethics specific to the critical care area, let's start out with a brief review of the fundamentals, the four ethical principles taught in all nursing programs: respect for autonomy, beneficence, nonmaleficence, and justice. I'll go through them one by one. Keep in mind, they each carry equal weight and I'm discussing them in no particular order. I'll start with respect for autonomy. Respect for autonomy is acknowledging or rather respecting that an individual has a value system and the right to make choices and take actions based on that personal value system.

*Rachel:*

What?

*Andrew:*

In the critical care environment, nurses demonstrate respect for autonomy by (1) maintaining an attitude that respects the person's values and beliefs and, (2) through actions that demonstrate a respect for the person's values and beliefs. Here's an example. An adult patient with severe anemia makes a decision based on her religious beliefs to refuse a life-saving blood transfusion even after being fully informed of the benefits and risks. By changing the plan of care to exclude blood products, the critical care team respects her autonomy.

*Rachel:*

Oh, okay.

*Andrew:*

Now I want to explore autonomy a bit further. It's not an all or nothing thing. It all depends on a person's *liberty* and *agency*. Liberty and agency are the two conditions that must be present for an individual to be considered autonomous. To have liberty means you are not controlled by outside influences and a to have agency means you have the capacity to act with intent. When

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liberty and agency are absent, the person lacks autonomy. Think about the adult patient who is blind, non-verbal, immobile, and with cognitive disabilities. That person is completely dependent upon his caregivers to provide for his hygiene and nutrition needs. He is under the influence of his caregivers and does not have the ability to act with any intention.

*Rachel:*

Okay, but what about when you have one, or the other?

*Andrew:*

He has no liberty or agency; he lacks autonomy. What about a person who has liberty but no agency or vice versa? That person has diminished autonomy. Consider, a young woman who is paraplegic following a motor vehicle accident who has lost her ability to move but still has the ability to make her own decisions and convey her wishes to her health care team. She has varying degrees of liberty and agency; she is not completely under the influence of her caregivers and has some ability to act with intention. She has diminished autonomy.

Alright, it's time to move on to beneficence. Beneficence is the moral obligation to act for the benefit of others guided by commonly assumed obligations. In other words, doing something that benefits another person based on a universally accepted belief as to what is beneficial. These commonly assumed obligations are referred to as prima facie rules. This means these obligations are self-evident until proven otherwise: The prima facie rules include (1) the protection and defense of human rights, (2) preventing harm, (3) removing conditions that cause harm, (4) helping the incapacitated, or those that lack autonomy or have diminished autonomy, and (5) rescuing individuals from danger.

### **Module One: The Basics**

#### **Video 4 – Part 2: The Principles**

#### **Featuring Rachel**

*Andrew:*

But let's be clear, there is no expectation for ideal beneficence. We are not obligated to follow all the prima facie rules all the time, for all people. For example, when you reposition a sedated, mechanically ventilated patient every two hours to prevent the patient from developing pressure related injuries you are fulfilling some of the prima facie rules. When you initiate an adult protective services inquiry after noticing unexplained injuries in various stages of healing on a newly admitted elderly patient who tells her he doesn't feel safe at home with his caregiver you are acting to fulfill all five prima facie rules. Can you think of any other situation you've encountered in which some of these rules were honored? All five?

*Rachel:*

I can think of a time when I have to follow these rules and I don't really want to, like when you have a patient who is a drug addict and they're continuing to hurt themselves and I'm here having to take care of them. Meanwhile, I have a patient over here who's got lung cancer from second hand smoking who's lived her life fine and she's about to die.

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*Andrew:*

Keep in mind, no one is morally compelled to perform extreme acts for the benefit of all persons nor is there an expectation that all persons should benefit on all occasions. One last important point. Beneficence in health care is *obligatory* beneficence. Let me explain. As a registered nurse you assume a duty to your patient and this duty creates a relationship that bestows upon you an obligation to follow the prima facie rules. The key is the establishment of the relationship between nurse and patient.

The third principle is nonmaleficence. The simple definition of nonmaleficence is to avoid causing harm to a person or placing a person at risk for harm. Harm in this definition is an act that hinders a person's interest.

Situations that arise in the ICU are not clear cut and this simple definition of nonmaleficence and harm just isn't adequate. Instead, health care ethics has refined the definition of nonmaleficence by making harm contextual. It depends on the context or circumstances in which the harm occurred whether or not the standard of nonmaleficence was met. Why? Because in the ICU, not all harmful actions are unjustified. For example, a patient in the intensive care unit arrests and advanced cardiac life support is initiated. He survives but has several broken ribs from the chest compressions and superficial burns from the defibrillator pads. He experienced harm in that he was injured during resuscitative measures. However, the harm was justified – it did not hinder his interests, in fact advanced his interests in that it saved his life. Here's another example: You have a patient assignment in which one of your patients is on contact isolation for MRSA. You make certain to always wear protective equipment while in the contact isolation room to avoid cross contamination with other patients. In other words, you are making sure you don't place anyone at risk by spreading MRSA. That example used the simpler definition of harm. But I wanted to include it because I want to demonstrate that even the most clear-cut situations and the most routine nursing care has ethical implications. Your nursing practice is part of the ethical environment you work in.

The final principle to discuss is justice. Simply put, justice is fairness in what is owed to an individual. If it was only so easy. The concept of justice is complex and a simple definition does not adequately cover all instances of justice in health care ethics. Therefore, several theories of justice are applied in health care. These theories fall into two categories: procedural justice and distributive justice. Procedural justice asks the questions: are there processes in place that ensure equity? Are these processes being followed? Distributive justice asks the questions are resources being distributed equally? Are they being distributed fairly? Both procedural and distributive justice theories are used in health care settings. Here's what I'm sure is a familiar example. After examining the in-coming shift staffing report and the hospital's census, the house officer determines that several nursing units will be short staffed for the night shift. The house officer is applying procedural and distributive justice principles by deciding to float nurses between units to cover the entire hospital's staffing need and by using the float log and the staffing matrices to determine which units will be affected and which nurses will be floated to ensure the safety for the greatest number of patients.

*Rachel:*

Alright...so you know when you get that call you're going to get floated to the other unit and that really sucks, because you want to be on your home unit where you know where everything is, or you know who everybody is, or you could have been on call. But I guess if the ICU is

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staffed, and there are patients in need of nurses and we are preventing those patients from being, from receiving missed care, because their nurses are so short, I guess that's justice...I guess I have to suck it up a little bit.

And that wraps up the four principles that serve as the basis for health care ethics. To continue this brief review of the fundamentals, proceed to the next video in module one.

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### **Module 1: The Basics** **Video 5: Clinical Ethics** **Featuring Rachel**

*Rachel:*

Alexa, stop!

*Andrew:*

Before I delve too far into the health care ethics of the critical care environment, I should answer the question: what exactly is health care ethics?

*Rachel:*

Yeah, how about you answer that.

*Andrew:*

I'll start by saying there is a lack of consistency in the terminology used when discussing ethics in hospital settings. Terms such as clinical ethics, medical ethics, bioethics, and health care ethics are commonly used interchangeably; however, this is not correct. These terms represent different fields of study. To clarify, bioethics refers to the application of ethics to the biological sciences while medical ethics refers to the application of ethics to the practice of medicine. Clinical ethics is a term used to describe the framework that assists health care providers to resolve the ethical issues that arise in clinical practice. Health care ethics is used to describe the application of ethical principles to situations that arise in the health care setting; this includes direct patient care situation and the processes and policies that guide health care. I should also add that these terms are not an exhaustive review of the ethical frameworks that can be used in health care. It's also important to recognize that the term ethics is in itself a generalization. Ethics can be further broken down into specific fields of study. Three common fields of study are normative ethics, descriptive ethics, and applied ethics. Normative ethics is the study of what individual should do and if their actions are morally reasonable; it involves evaluating people's choices and actions. Descriptive ethics is the study of how people behave and what they find morally acceptable; as the name suggests it involves only describing situations. Applied ethics is the study of how we make moral decisions and then implement these decisions. We use all three of these fields of study in the ICU.

*Rachel:*

That's a lot.

*Andrew:*

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I'll explain: Consider the patient who does not wish to follow the recommended dysphagia diet despite being fully informed of the risks of harm caused by aspiration. Descriptive ethics examines why the patient chooses to disregard the recommended diet in spite of the risks. Normative ethics attempts to determine if it is morally acceptable for the patient to act in a manner that could lead to harm. Applied ethics is used by the critical care team to determine if allowing the patient to risk aspiration in the hospital setting is morally acceptable and then formulating a plan of care for nutrition based on that determination. That wraps up the brief review of the fundamentals. Now it's time to think about what you have learned, relate the content to your everyday life and too your nursing practice. Take a minute, a couple of hours, or a few days but don't take too long. Keep the content fresh in your mind. Once you've formulated your thoughts, be creative and store your reflections on the private discussion board in any way you wish. If you think it will be helpful, watch Jane's interview again. When you're done posting, continue to Module 2.

*Rachel:*

Maybe just a couple more hours.

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### **Module 2: What the Critical Care Nurse Encounters**

#### **Video 6: The complexity of the ICU environment**

##### **Featuring Allie**

*Andrew:*

Now I'm going to get critical care specific. I'll start by relating to you what the critical care nurse encounters in the ICU and while I do that, I want you to start reflecting on the environment critical care nurses function in. The environment is not an easy one to work in, the ICU is a demanding practice setting filled with daily stressors. Nursing in such a challenging atmosphere is nothing new, it's part of the profession's history. The physical, mental, and emotional demands can be traced back to the time of Florence Nightingale and the first "intensive nursing care" units in military field hospitals.

The nursing care provided in these first "intensive nursing care" units centered on hygiene and comfort; the ICU nurses of today are responsible for much more. Your duties require that you have the knowledge base to manage the most complex clinical presentations and the skill set to operate the most advanced health care equipment.

*Allie:*

You got that right. I don't know, if they used to consider that intensive care, what would Florence Nightingale consider what we do today?

*Andrew:*

These advances in health care interventions and changing societal norms have come together to create a critical care ethical milieu where it is common to see tension exists between the ethical principles of autonomy, beneficence, nonmaleficence, and justice. Consequently, ethical dilemmas and ethical problems permeate the critical care setting.

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An ethical dilemma or problem as a lived experience, is conflict. Therefore, one could say that the critical care setting is rife with ethical conflict. Ethical conflict in this setting is diverse ranging from disagreements on implementing or limiting life sustaining treatments to disputes over staffing and duty assignments. It stands to reason that to meet the challenges inherent to this practice environment the critical care nurse must have clinical and technology-based knowledge and an ethical skill set that includes an understanding of and the ability to apply the principles of health care ethics. In addition, these ethical skills must be developed enough so that the critical care nurse has the ability to see the ethical implications of everyday nursing care. Now that we've stated the obvious, that working in the ICU is challenging. Let's explore what makes it so hard.

### **Module 2: What the Critical Care Nurse Encounters**

#### **Video 7: Interdisciplinary conflict**

#### **Featuring Allie**

*Andrew:*

One of the greatest challenges in the ICU is the presence of interdisciplinary conflict. This isn't conjecture. Interdisciplinary conflict has been identified in the literature as a significant source of ethical conflict in the ICU. So, what is there to be conflicted about in the ICU? Researchers have identified several common sources of interdisciplinary conflict that occur in ICUs. The most common disagreements center around decisions over life-sustaining treatments, patient's pain control, and team communication.

Who is experiencing this conflict? Granted, conflict exists between all the health care disciplines. However, the most studied interdisciplinary conflict specific to the ICU is the conflict that occurs between nursing and medicine. Why is there conflict or uncertainty? Why are nursing and medicine in disagreement so frequently? What does the research say is at the root of the conflicts?

**Divergent goals** – Several studies demonstrate that at the root of conflict between nursing and medicine is a philosophical difference in the approach to patient care and the belief that each discipline knows what is best.

**Another is Power imbalances** – Another source of interdisciplinary conflict found in the literature is the belief held by critical care nurses that their voices are not heard – the lack of autonomy – that nursing's knowledge is not given equal consideration by medicine in decision making processes regarding patient care. Consequently, critical care nurses feel their skills and knowledge are undervalued leading to animosity and discord.

**Differing perceptions** – There is even a difference in viewpoint as to the nature of interdisciplinary conflict. The literature reveals that medicine believes that nursing is responsible for maintaining its subordinate position thereby devaluing itself. There is also disagreement as to whether or not interdisciplinary conflict is actually present in the critical care setting with medicine believing the quality of collaboration is higher than what nursing believes.

**Misunderstood roles** – There is little research investigating whether or not nursing and medicine understand each other's responsibilities on the health care team and the values that shape how these responsibilities are assumed. These misunderstandings contribute to the conflict.

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So, I've given you a brief explanation of the challenging conditions that critical care nurses face. It's time to reflect on these conditions and post your thoughts on the discussion board. Gabby's interview started this section and you can go back to it if you want. But remember, this discussion board is personal to you. When you're done, move on to Module 3.

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### **Module 3: What the Critical Care Nurse Experiences**

#### **Video 8: Moral Accountability**

##### **Featuring Rachel**

*Andrew:*

I've talked about the what the critical care nurse encounters that makes the ICU an ethically demanding place. Now I'll get into what the critical care nurse's inner self experiences working in such an ethically challenging environment. You may already be familiar with these concepts, but it's important to have a solid understanding of them.

I'll start with moral accountability. Moral accountability is the willingness of an individual to take responsibility for one's actions and inactions; it's your capacity to own your actions or inactions both personally *and* publicly. Your moral accountability is determined by your moral obligation. Meaning, if a person has a moral obligation to someone or something (a government, a school, a church, or a profession), then he or she also is morally accountability to that someone or something. How this is applicable to critical care nursing? Well, critical care nurses are morally accountability to two entities: their patients and their discipline. Why? Because they have an obligation to both their patients and their discipline. Let me explain. The proximity to patient care situations and the intimacy that develops between critical care nurses and their patients confers or places upon critical care nurses a moral obligation to their patients, hence a moral accountability to their patients. The critical care nurse's obligation to the profession stems from the professional code of conduct. The Nursing Code of Ethics with Interpretive Statements states that a professional nurse has a duty or moral obligation to be a professional member meaning a professional nurse is morally accountable for how their practice reflects on the entire discipline of nursing.

Being accountable is a huge responsibility.

*Rachel:*

Like I don't have enough responsibility.

*Andrew:*

In the next video, I'll talk about the implications of this responsibility on the inner self.

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### **Module 3: What the Critical Care Nurse Experiences**

#### **Video 9: Moral distress**

##### **Featuring Rachel**

*Rachel:*

No, no.... alright.

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*Andrew:*

Moral distress is the lived experience of a perceived ethical dilemma or conflict of principles; it's an acute moment of moral disequilibrium. It was first defined as the internal conflict an individual perceives when unavoidable circumstances prevent him or her from acting according to his or her beliefs of right and wrong. Now, this first conceptualization implied that the individual experiencing moral distress held the view that only his or her beliefs were morally correct. However, the definition has evolved and it is more accurate to say the distress stems from an individual feeling his or her beliefs of right and wrong are not respected. For example, a patient with stage IV colon cancer with metastatic disease is admitted to the ICU with respiratory distress secondary to a recurrent malignant pleural effusion. This is her third admission in the last six weeks. The ICU nurse has taken care of this patient during her prior admissions and knowing the patient has been considering hospice care suggest a palliative care consult to address goals of care and symptom control. The attending physician disagrees and feels the priority is treatment of the acute problem/malignant effusion. The ICU nurse feels dismissed and disappointed at the direction the plan of care is taking. This situation is morally distressing because the nurse has been put in a position to feel disregarded. Her belief that the patient's voice should be heard has been dismissed and she is unable to take what she believes is the right course of action. In this case, that would be to facilitate her patient's desire to explore hospice care services.

*Rachel:*

Of course, she feels like that. What is with these doctors that makes them think that they can just focus on the acute problem and not look at the big picture. This person is suffering from end of life terminal cancer and that she has voiced her desire for hospice yet they think that they can fix this tiny little insignificant pleural effusion, the third one she's had...in a week?

*Andrew:*

So why is knowing about moral distress important? Because we need to work towards alleviating it. Why? Because we're discovering that moral distress has a negative impact on critical care nurses and their practice; it has been found to be associated with severe burn out, high staff turnover rates, diminished feeling of self-worth, physical and psychological ailments, and most concerning, poor patient care. Fortunately, investigations into critical care nurses' experience of moral distress have given us a better understanding of the factors that contribute to its development; these factors include: (1) poor quality of communication between the nurse and physician, (2) feeling devalued or lack of psychological empowerment, (3) organizational challenges, (4) feeling that advocacy efforts have failed, and (5) lack of limit setting during end of life care. By knowing why moral distress develops we can start working towards easing the burden.

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### **Module 3: What the Critical Care Nurse Experiences**

#### **Video 10: Moral Resilience**

#### **Featuring Rachel**

*Andrew:*

In the prior video I talked about the problem of moral distress. Now, I'm going to talk about a potential solution and tie it to being morally accountable in your practice.

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Moral resilience is an individual's capacity to maintain, reestablish, or strengthen his or her integrity in response to ethical conflict. It's based on one's self-awareness of and commitment to his or her value system. Your ability to be morally resilient hinges on you knowing exactly what is important to you. It's a promising area of nursing research because of its implications in regards to moral distress and moral accountability.

What's great about moral resilience is that it can be fostered. Developing it involves developing skills in self-awareness, self-regulation and emotional intelligence. It takes developing one's ethical voice and ethical competence. You have to be able to recognize there is meaning in distressful situations, and appreciating these situations can be opportunities for positive change. Lastly, it can be fostered at a systems level meaning you can advocate for practice environments that support your efforts to foster your individual moral resilience. You don't have to do it alone.

*Rachel:*

Who else is going to help me out? The, the system doesn't care about what I'm going through, that's why we have moral distress. They just care about the bottom line.

*Andrew:*

How does moral resilience relate to moral distress? It's showing promise as being a potential solution. Key to understanding the connection is recognizing that it is a coping mechanism. It is a positive adaptive response to a perceived negative, in particular the ethically challenging situation. Moral resilience gives a person the ability to reframe negative experiences and see them as opportunities for positive change. Finding the positive in a morally distressing situation, or being morally resilient, eases the burden on the inner self. Another plus to being morally resilient is that it is consistent with ethical nursing practice. By developing your ability to be morally resilient you are enhancing your ability to maintain moral accountability in the most distressing situations.

I've talked about moral accountability, distress, and resilience. It's time to reflect on these concepts and post your thoughts on the discussion board. Watch Cory's interview again if you need some inspiration but make sure you post something meaningful to you. I want your post to reflect your unique ideas and experiences. When you're done, move on to Module 4.

*Rachel:*

Alright, goodnight everybody.

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### **Module 4: Navigating the Complex ICU Environment**

#### **Video 11: Identifying Ethical Dilemmas**

#### **Featuring Allie**

*Allie:*

Okay, try to knock out as many of these as I can...get this cake made. I'll be good.

*Andrew:*

I've introduced you to what critical care nurses encounter in the ICU environment and what their inner selves experience. Now I'll touch on how they navigate this complex environment. How

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do critical care nurses tackle the ethical problems and dilemmas, the ethical conflict that come up in everyday practice? But wait, before we get too deep into the how, I want to point out the difference between an ethical dilemma, a practical dilemma, and an ethical problem or ethical issue. An ethical dilemma is a clash of value systems. The choices involved in ethical dilemmas are value laden and as a result they present an individual with more than one course of action that appears to be of matched moral significance, and contradict each other. Because of the moral conflict and contradiction, there is *no solution* to an ethical dilemma that provides a satisfying resolution. That said, ethical dilemmas should not be confused with conflicts of opinion, preference, or a practical dilemma. A practical dilemma is driven by self-interest. On the other hand, an ethical problem or issue is a situation in which a problem arises that when ethical principles are applied has a clear solution. Let's compare two situations:

A patient in the ICU is experiencing a gastrointestinal hemorrhage secondary to his outpatient oral anticoagulation regimen. There is no reversal agent for the anticoagulation and all attempts at controlling the bleeding have been exhausted. The patient's family has been informed of the extremely poor prognosis; however, they wish to continue treatments. He has already received multiple blood products and the director of the blood bank informs you that she has reservations issuing any more products for what appears to be a futile endeavor.

Is this an ethical dilemma or problem? Ask yourself: Does this patient have the right to fight for life at all costs? Does this situation present an inappropriate allocation of resources? What do you think?

*Allie:*

How am I supposed to make that decision when I'm so...connected emotionally to the patient at the bedside with their family?

*Andrew:*

Both moral claims have merit (the right to life versus the just allocation of resources) and neither claim is stronger than the other. This makes this situation an ethical dilemma. Now consider this scenario:

For several months, the charge nurse of the ICU has suspected that a staff nurse has been diverting albuterol nebulized solution for personal use. The ICU nurse in question is the charge nurse's personal friend and because of their close relationship the manager knows that the nurse has a son with asthma. She also knows that the nurse has been struggling financially. During her lunch break, the charge nurse sees her friend and colleague place an albuterol solution packet into her lunch kit and confronts her about her actions. The ICU nurse tells her that she just doesn't have the money for medications right now and her son really needs these treatments adding "I'm only taking the PRN medications from the patients don't even need or use them." The charge nurse feels torn. Should she say nothing or should she report what she knows to the manager? Is this an ethical dilemma or problem? Ask yourself: is there a clear distinction of right and wrong in this situation? Are there any moral claims? Are there clear ethical guidelines in place to guide both nurses' actions? Are there issues of self-interest or opinions at play in this case? What are your thoughts?

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*Allie:*

Same as before, I can feel the emotions involved with being close friends with the nurse, but it's just not right.

*Andrew:*

Only one moral claim has merit in this case – the claim backed by the professional code of conduct. No matter how much compassion or sympathy the charge nurse has for her friend's situation, she has a moral obligation to report conduct that is not in keeping with nursing's code of ethical conduct.

Okay, let's back up and think about this one last scenario:

After a long stressful shift in the ICU a nurse comes home to a starving family. The kids ask "what's for dinner?" The nurse thinks – I could make a healthy home cooked dinner or I could order a pizza. What should I do?? Is this an ethical dilemma? An ethical problem? No. It's a practical dilemma. The RNs choices have no moral claim and there are no clear moral wrongs. This is a dilemma of self-interest.

In order to successfully identify ethical dilemmas, you must have a clear understanding of the moral obligations or value systems driving in the dilemma. It's also important to realize that you must always be aware of the ethical implications of your practice. Our actions do not occur in a vacuum and what seems like routine ICU nursing care influences the ethical climate of the ICU. This includes having a clear understanding of the values that you bring to the situation; to be objective in assessing the situation you must first acknowledge the lens through which you are perceiving the dilemma. I hope this helps you make the distinction between the true ethical dilemma and the ethical issues or problems you may come across in your practice. Next, I want to talk about some ways ethical decisions are made.

### **Module 4: Navigating the Complex ICU Environment**

#### **Video 12: Ethical decision-making**

#### **Featuring Allie**

*Andrew:*

In the last video I pointed how important it is for critical care nurses to be able to identify ethical dilemmas and problems. Now I want to talk about how to make ethics-based decisions.

An ethical-decision making model is a set of guidelines that are used to assist an individual in making decisions consistent with a particular ethical framework. There are several ethical-decision making models used in nursing found in the literature. Understand that ethical decision-making models are developed based on a particular ethical philosophy or framework and assume that critical care nurses have prior knowledge of the ethical principles or philosophy the model is based upon. These models also require that the utilizer be skilled at conflict recognition. An ethical framework is a set of moral principles or moral code used to guide decision making. There are numerous ethical frameworks discussed in the literature. The most frequently used in nursing include the medical ethics, virtue ethics, health care ethics and bioethics.

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You may be wondering, do critical care nurses use ethical decision-making models? Yes, you do. Everyday. Everything you do, even the most basic nursing care has ethical implications and since it seems so routine you may not realize that you are making ethical decisions or what the decisions you are making are based on. You can become more ethically aware by familiarize yourself with the model that your unit employs for ethical decision-making, attain a clear understanding of the ethical principles or framework the model is based on, and develop your skill in ethical conflict /dilemma recognition. If your unit doesn't utilize a particular ethical decision-making model, then knowing the ethics that guide your practice, your personal ethical code becomes more important; knowing how to identify ethical dilemmas becomes imperative.

I want to take a step back. Why are so many of these ethics-based decisions going unnoticed? Actions that are the result a consensus of compatible values are often overlooked as being ethics based. Conversely, actions that are surrounded with ethical conflict are quickly recognized as based on ethical decision making.

I want to reiterate that there is a natural tendency to forget how value laden the critical care environment is when there is no conflict of values to serve as a reminder. It's up to you to always be mindful that you act on ethics-based decisions in times of conflict and in times of harmony. Also, keep I mind that how you act on ethics-based decisions depends on the circumstances surrounding the action. Acting in times of ethical harmony is easy and can even seem routine. Acting in times of conflict may be more difficult especially if the action in question contradicts your personal values.

That said, there may be instances in which you find yourself in a situation that demands you take an action that you believe is morally untenable. The expectation is not that you take an action that violates your morals; an ethically sound workplace will have processes in place to assist you in maintaining their ethical integrity. It is fundamental that you be aware of the support services and resources available to assist you in case you find yourself in a situation that challenges your moral integrity. Always remember, we do not maintain ethical practice in isolation, working together to maintain each other's moral integrity it is just another aspect of the teamwork inherent in critical care. If you are unsure where to seek support for your ethical concerns, Chaplain services or the ethics committee representative in the facility is a good place to start.

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### **Module 4: Navigating the Complex ICU Environment**

#### **Video 13: Conflict resolution techniques**

##### **Featuring Allie**

*Andrew:*

I talked at length about conflict. Now I want to briefly touch on conflict resolution.

A consequence of the critical care nurse's close proximity to patient care situations is that they are often directly involved or very close to the ethical conflict that occurs in the course of their patient's ICU stay.

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Expertise in conflict resolution is not required to be a ICU nurse, however, critical care nurses do have a moral obligation to take an active role in conflict resolution; it is part of the moral accountability you have to the patients and to the profession. That said, part of the critical care skill set is having basic conflict resolution skills.

How do you go about gaining conflict resolution skills? First, know that conflict resolution hinges upon clear communication. When conflict arises, you are in the ideal position to take the first steps towards reconciliation by communicating with the patient or surrogate and encouraging them to communicate in return. The goal of the exchange is to gain an authentic understanding of the patient's or surrogate's position on the issue of contention.

STADA (Sit, Tell, Admire, Discuss, Ask) is a method used in ethical mediation to clarify goals of care. This method can also be used by critical care nurses to engage the patient or surrogate in effective communication. I'll go over each element one by one.

First is Sit –

*Allie:*

Sit? When do we have time to do that??

*Andrew:*

The ICU is a busy place and you rarely has time to sit; however, this step is perhaps the most important in the process. Sit down and talk to talk with the patient and his or her family. It's a silent but powerful acknowledgment that what they have to say is important.

Tell – Ask the patient to tell you about himself or ask the surrogate to tell you about the patient. By listening to what they have to share, you can gain valuable insight into what they value.

Admire – Acknowledge the time that was taken to speak to you and the courage it took to share with you. Admire the patient's efforts or the surrogate's efforts to be engaged in the health care process.

Discuss – After you've listened and validated the participation of the patient or family, you can now begin to discuss with the patient or the surrogate the objective facts of the patient's condition and treatments.

Ask – The last step is asking the patient or the surrogate if they understand what you have communicated and if you have a clear understanding in return. Using open ended questions is a good strategy when asking for clarification because it allows room for further exploration of thoughts and feelings.

The STADA technique is also effective in facilitating communication between the critical care team members.

*Allie:*

It would be nice...if we could actually have time to all sit...together, in one spot and really talk.

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*Andrew:*

But keep in mind, STADA does not resolve conflict; its intention is to facilitate communication which can then lead towards resolution, compromise, or a respect for differing positions.

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### **Module 4: Navigating the Complex ICU Environment**

#### **Video 14: Novice to expert: mentoring as an ethical approach**

##### **Featuring Allie**

*Andrew:*

I'm sure you already know the ICU is a challenging practice environment even for the most experienced nurses. For the novice critical care nurse, the practice environment can be overwhelming. The novice is not only learning the skills and knowledge base necessary to care for the physical conditions of the critically ill patient; he or she is also learning his or her role in the ethical environment of the critical care setting. Learning the ethical role of the critical care nurse presents more of a challenge than learning the practical role. Why is that? Well, practical experiences can be manipulated. Efforts are made to avoid making patient assignments that exceed the skill set of the novice. Skill building opportunities are planned learning experiences and novices are mentored and coached as they practice. Conversely, the ethical climate of the critical care unit cannot be tailored to the learning needs of the novice nurse. The novice nurse experiences the ethical demands of the critical care setting in real time, with no regard to their ethical skill set.

*Allie:*

I wish they told me that, before I started.

*Andrew:*

One approach to helping novice critical care nurses navigate the complexities of the ethical environment is mentoring. Experienced critical care nurses who are adept at meeting the ethical challenges of the critical care setting can serve as teachers and mentors to the novice critical care nurses. Mentoring ethical skill building is more than an educational strategy aimed at increasing the skill. You have a professional obligation to create an ethical practice environment. This means that the experienced critical care nurse has an obligation to coach the novice in ethical skill development and the novice critical care nurse has an obligation to seek out mentors that can support them in their skill development. I've spoken to the importance of honing your ethics skill. It's time to reflect on the content and post your thoughts on the discussion board. Watch Nan's interview again if you need to and post a reflection that speaks to your thoughts and experiences. When you're done, move on to Module 5.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 15: End of life**

##### **Featuring Melissa**

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*Andrew:*

This final module is a discussion on the most common ethical challenges in critical care. I've saved this for the end because it's my hope that you can see concepts you've learned so far interwoven in this material. I'm going to start by talking about something that we will all face one day; end of life.

The majority of ethical conflict in the critical care environment finds its origins in end-of-life issues. Individual end-of-life issues are ethically charged for multiple reasons. However, the root of the ethical conflicts that surround all end-of-life issues is the changing perception or changing definition of end-of-life. End-of-life is no longer limited to simple definitions of death and dying; it has become much more complex.

Life-saving and sustaining treatments have changed what end-of-life means, and what it looks like. Survival rates for the most severe traumas, brain injuries, cardiac events, and infections grow higher everyday due to advances in health interventions. The terminally ill patient's life can be sustained longer. A person can be declared brain dead yet still have a heartbeat. What end-of-life looks like today is not what end-of-life looked like 20 or even 10 years ago. Furthermore, we can expect what end-of-life looks like to continue to evolve as medicine and nursing evolves. Because it is so complex, there is great variability in how end-of-life is perceived. Naturally, these perceptions are influenced by individual value systems. With so many value laden layers it is understandable why end-of-life issues result in so much ethical conflict.

So, what does end-of-life look like in the ICU, from an ethical point of view of course? It's somber to consider, but end-of-life issues are routine in the ICU. Critical care is an end-of-life specialty; critical care teams specialize in saving and sustaining life and in death and dying. Even when the critically ill patient survives and is discharged from the ICU, sometime during his or her ICU stay end-of-life issues were present.

Every day ICU nurses find themselves participating in advanced care planning, explaining do-not-resuscitate orders, determining a patient's desires to continue treatment or to stop treatment, having goals of care discussions, listening to surrogate decision makers, and even defining death for families. These tasks don't involve a physical act like most critical care tasks; however, they are vitally important collaborations that serve as the foundation for a patient's end-of-life care. The challenge is that these collaborations concern subjects that are heavily value laden and consequently high risk for conflict.

The role of the critical care nurse in end of life issues is one of the most important nursing responsibilities in critical care. Your role as a critical care nurse in end of life issues (in terms of ethics) is to create a care environment that facilitates decision making that follows the principles of health care ethics. This means you know what these principles are, you possess a self-awareness of how your value system influences the application of these principles, and you recognize how the value systems of the patients and surrogate decision makers impact decision making, and ensuring that the patient and surrogate's values are respected by the entire team. All these activities involve a large degree of self-reflection and education. These activities are the ethical compass of the critical care unit.

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In addition to educating yourself and engaging in activities that foster self-reflection, you have a duty to provide the education that patients and families need to make informed, ethics based end of life decisions, a duty to encourage self-awareness and value identification in patients and families, and a duty to encourage self-awareness and value identification in your colleagues.

*Melissa:*

That is probably the most important part, is to make sure all of the team is on the same page. There's been many times when you've worked with a family for hours talking to them and they're moving towards comfort care and the physician will walk in and notice some small improvement like "oh their white count went from 29.6 to 29.5 and I see improvement here, and we're going in the right direction" and then the family is immediately you know off and running and forgetting all of the comfort care, end of life discussions you just had with them.

*Andrew:*

These activities are by no means easy and the you may find it incredibly difficult at times to reconcile the values of the patient and surrogate decision makers with your own values. However, critical care teams do not practice in isolation. The hospital and support services provide resources to assist you in times of ethical conflict. The palliative care team, chaplain services, case management, and the ethics committee are just a few of the departments that can help you navigate the ethical aspects of end of life issues.

### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 16: Patient's rights, provider's professional integrity and the just allocation of resources**

##### **Featuring Melissa**

*Andrew:*

You've learned that the relationship between critical care nurses and their patients is an intimate one, based on moral obligation and accountability. A large part of fulfilling this obligation and being accountable is being a patient advocate and speaking up for "patient rights," and making sure that the resources on your unit are allocated fairly, all while maintaining your professional integrity. I want to talk about these challenges.

I'll with patient rights. What are patient rights? What are critical care nurses actually advocating for when they say they are protecting the "patient's right?" The term can be misleading. It's used in multiple contexts and has very different implications depending on the context. That said, to be an effective patient advocate you have to know the context. In the ICU, you have to consider legal context and moral context. A patient's legal rights and a patient's moral rights are very different. It's important not to confuse them or use them interchangeably. Let me explain.

Moral rights are the rights that are based on our common humanity; all people have these rights by virtue of being human. For example, all people have a right to food, water, clothing, and shelter; there is no moral argument that justify denying any human being these rights. They are absolute. Legal rights are the rights that are legislated; patients have these rights because a

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legislative body granted these rights. For example, the Patient Protection and Affordable Care Act of 2010 established the patients' legal rights in terms of access to health care. Legal rights however are not absolute; moral arguments might justify denying or limiting these rights.

In addition to being aware of context, it is important for the ICU nurse to know and use the correct terminology. It's common in the critical care setting to hear statements such as "a patient's right to die" or "a patient's right to all treatment options." These statements are inaccurately conveying valid concepts. "A patient's right to die" is more accurately stated as patient's right to refuse any and all care. "A patient's right to all treatment options" is actually the patient's right to receive equitable treatment. Using the correct terminology and phraseology is so important because it can strengthen or weaken the moral argument supporting the concepts.

You can't discuss patient rights without addressing the fair distribution of health care resources. This is an extremely very value laden and conflict filled topic, and there aren't any clear answers. But as the primary bedside caregiver in the ICU, you may find yourself in the position of having to broach these difficult conversations with patients, their families, and other members of the hospital team, so it's a topic that you should be familiar with.

So why is fair distribution a concern? Because health care resources are finite. There is not an unlimited amount of resources to allow for society to provide limitless health care. So, what do we do? We apply the principle of justice. Society has a responsibility to see that health care resources are justly or fairly distributed. Only by being good stewards of these finite resources, balancing the cost versus the benefit, can we ensure their just or fair distribution. That said, applying the principle of justice in health care means individuals have a right to an *equitable* amount of health care at a manageable cost. No individual has a right to limitless healthcare at the expense of another.

Being able to make moral arguments based on ethical principles on behalf of patients sounds daunting. But it's like any other skill the ICU nurse needs to function, it can be acquired and developed. So how do ICU nurses acquire the skill? By maintaining professional integrity. Doing that starts with understanding your moral compass. Your moral compass is what guides you and it is shaped by two moral codes or ethics: your personal ethic and your professional ethic. Your personal ethic answers personal questions such as: what is important to you? How does what is important to you shape your values? How do these values shape your decisions? Your professional ethic is what guides you as a professional nurse; for professional critical care nurses, the tenets of the Code of Ethics for Nurses with Interpretive Statements serves as the guide for their professional ethic. Together these two ethics, your personal and professional ethic, come together to create your moral compass.

*Melissa:*

You know, we all learned about the Nurse's Code of Ethics in nursing school, but after that I never thought about it very much at all. It seems like it's very difficult to put those together with everyday patient care and when you get to work it's, we just don't talk about it. Maybe that's something that we should start talking about on our unit to figure out how to integrate the code of ethics into our daily care of our patients.

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*Andrew:*

Knowing your moral compass, being aware of the ethics that drive your practice strengthens your professional integrity. There will be times in the ICU when your professional integrity is conflicted, especially when patient's rights are ethically opposed to your own moral compass. In these situations, it's vital to recognize that there will be no resolution to the ethical conflict. However, also remember that you are in no way morally obligated to compromise your professional integrity. Respect for value systems is mutual; the provider, the patient, and the healthcare facility must all respect each other.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 17: Brain death – Part 1**

#### **Featuring Melissa**

*Andrew:*

Brain death is probably the most publicly well know ethical challenges in critical care units. It's a condition that all ICU nurses need to be prepared to face.

Brain death was first defined in an article published on August 5, 1968. The authors of this article were members of an ad hoc committee at Harvard University Medical School led by Dr. Henry Beecher with the purpose of "defining irreversible coma as a new criterion for death." At the time, there were many organizations all over the world considering a definition of brain death. The Harvard Committee published the first and most comprehensive definition. This is the definition they published: Coma could be considered irreversible and a patient declared dead if over a 24-hour period: (a) there is no response to stimuli, (b) no spontaneous movement, (c) no breathing, (d) no reflexes, and (e) a flat electroencephalogram

At the time it was published, The Harvard Committee's definition had no legal weight. In the ensuing years, state laws were passed using the committee's recommendations as a guide. Because the states legislated the definition of brain death, there was great variability in how these recommendations were applied. Eventually the Federal government made efforts to bring some standardization to the definition of brain death in the United States. In 1981 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research addressed the problem of variability by developing the Uniform Determination of Death Act, the UDDA. The Uniform Determination of Death Act states "an individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

There are several key points to the Uniform Determination of Death Act that are worth emphasizing. First, it's important to recognize that this act provides a standardized legal definition for determining death; but not the medical criteria. Another key point is that it maintains that those authorized to declare death and do so according to the UDDA should not and will not be liable in any civil or criminal action related to declarations of death under the UDDA. Lastly, all 50 states have adopted laws that incorporate some of the UDDA; however, there is still variability in the definition of brain death in the United States.

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So, what are the medical standards to determine brain death and where did these standards come from? The American Academy of Neurology (AAN) has issued evidence-based guidelines to assist physicians in this difficult diagnosis.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 17: Brain death – Part 2**

#### **Featuring Melissa**

*Andrew:*

Per the AAN, physicians must determine two points (1) that all functions of the brain including the brain stem have ceased, and (2) that the lack of function is irreversible.

The AAN also has guidelines to determine cessation of function and irreversible coma. The cessation of function is determined by (1) the presence of unresponsive coma, (2) the absence of brainstem reflexes, and (3) the absence of respiratory drive after a CO<sub>2</sub> challenge. To declare irreversible coma providers must (1) know the cause of the coma, (2) exclude mimicking medical conditions, (3) and observe the patient for a period of time to exclude the possibility of recovery.

*Melissa:*

You know, that is one of the most delicate conversations to have with the family is to talk about brain death. So many of the, myself included, we don't really understand the criteria for brain death well enough to tell the family in a meaningful manner. I've seen fellow nurses really stumble when they start talking about brain death to the family and the criteria that's involved and it degrades the relationship when we don't appear like we're knowledgeable.

*Andrew:*

Even with these guidelines and legislation, brain death remains a challenge. In fact, brain death has always been controversial. The debate started 50 years ago over questions regarding the motivation for the Harvard committee's meeting. Was the primary motivation to resolve controversies surrounding the withdrawal of the new life supporting technologies that were keeping people in irreversible coma alive? Or, was it to increase the number of available organs for the new transplantation services? The final report claimed both motivations.

Although the diagnosis is much more accepted today than it was 50 years ago, it remains controversial because it is beleaguered with vague conceptualizations; specifically, that of society's understanding of death and the concept of integrated functioning. I'll explain. The paradox of an artificially sustained, yet still functioning body, absent of brain function being declared dead is incompatible with society's understanding of death. Another even more difficult concept to understand is that of integrated functioning. Integrated functioning is the term used to describe the ability of the brain regions to work together to process information and then use this information to stimulate bodily responses. Death is defined as is the loss of integrated neurological functioning; however, it has been demonstrated that integrated neurological functioning continues after the cessation of brain function. With such uncertainties it is no

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wonder that brain death is so provocative. Regardless of the ambiguities, it's a condition that the ICU nurse must learn to manage.

To bring this all together, there are some points that I want to highlight that the critical care nurse needs to consider when caring for a patient that has experienced brain death. First, you need to familiarize yourself with the medical criteria supported by the AAN and the criteria your facility uses to guide the determination of brain death and be aware what the state you are practicing in legislates. The UDDA states that life sustaining treatments can be withdrawn without requiring permission of the surrogate. However, one must also consider what the state law legislates.

Since there remains variability in state law, the critical care nurse must be sensitive to how this variability influences the families/surrogates of the patient who has been declared brain dead. Unfortunately, this variability contributes to the misunderstanding and misinformation surrounding the diagnosis of brain death. Perhaps the most important role of the critical care nurse is to provide families or surrogates with compassionate and objective education on the condition.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 18: Advance directives – Part 1**

##### **Featuring Melissa**

*Andrew:*

No discussion on end of life would be complete without a discussion on advance directives (AD)? ADs are at the center of end-of-life issues.

While EOL care and AD may be a part of the critical care nurse's experience when caring for patients, there are worrisome research findings regarding nurses' understanding of advance directives and their attitudes toward advance directives. Research reveals that many nurses in all nursing specialties (1) have a poor understanding of their role regarding AD, (2) do not know the federal and state laws regarding AD, and (3) as a result lack confidence or have misplaced confidence in regards to AD.

All that said, I want to go over key point regarding ADs starting with the definition.

An AD is a legal document that allows an individual to express in writing his or her wishes for medical treatment. Specifically, in the event an individual is unable to make medical decisions, the AD communicates what kind of medical care he or she would want to accept or refuse. Fundamental to this is the understanding that the patient has the right to make an AD, change or revoke that AD at any time.

AD is an umbrella term for several legal documents; three most common and universally accepted are the living will, medical power of attorney or durable power of attorney for health care, and the living will/MPOA combination document.

A living will is a document that clarifies patient preferences. It lists the life sustaining medical treatments a patient would wish to use, withhold or withdrawal. This document goes into effect

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when the patient is unable to make his or her own decisions; furthermore, in the case of withdrawing treatments the document goes into effect in the event the patient has a terminal illness or irreversible unconsciousness. Here's an example of a scenario in which a living will would apply. One week ago, Mr. L was admitted to the ICU after having an out of hospital cardiac arrest. On exam he has clear evidence of a severe anoxic brain injury and his prognosis for meaningful recovery is very poor. His living will states that he would not wish to have life-sustaining treatments to include mechanical ventilation and artificial nutrition and hydration if his condition is irreversible. Per his wishes, the ICU team and his family make plans to end life sustaining treatments.

A Medical power of attorney or durable power of attorney for health care is a document that formally appoints a proxy or surrogate decision maker for health care decisions and goes into effect when the patient is unable to make decisions on his or her own behalf. The MPOA acts as the voice/representative of the patient making decisions regarding health care for as long as the patient is unable to make decisions. Keep in mind there are several types of power of attorney documents. The MPOA is specific for health care decisions and is the only power of attorney that legally designates a health care proxy.

This type of document would be used in this scenario: Miss J was admitted to the hospital 2 days ago with a right lower lobe pneumonia. Upon admission she was awake, alert and oriented and able to make her own decisions. Last night she developed severe respiratory distress and required emergent intubation. She is now on mechanical ventilation and is sedated. The ICU team believes a bronchoscopy is warranted. Her MPOA names her oldest daughter as her health care proxy; the ICU team obtains informed consent for further treatments from Miss J's daughter.

The last document that you will commonly see is a Living will/MPOA combination document – this document is self-explanatory. It is a hybrid of the two most common types of AD and functions in both capacities.

From an ethical point of view, ADs are more than just a legal document. It has significant ethical implications you should recognize.

The ethical foundation of the AD is patient autonomy; however, the application of this principle to AD has evolved over time. Originally, autonomy in this context focused on simply protecting the patient's ability to make decisions. However, autonomy in the context of AD has evolved include the concept of informed consent. The autonomy associated with ADs has now become a reflection of the patient's decision making after being provided with information about the nature and consequences of medical treatments.

*Melissa:*

I never realized that informed consent was more than just permission of the patient to do a specific procedure. I never thought of informed consent being what guides our entire delivery of health care.

*Andrew:*

With this now evolved concept of autonomy, ADs have even more ethical significance.

**Module 5: Common Ethically Challenging Topics in ICU**  
**Video 18: Advance directives – Part 2**  
**Featuring Melissa**

*Andrew:*

They are a reflection of the patient's decision making after being fully informed about the nature and consequences of medical treatments to the extent that the patient can give proper consent for treatment or consent for nontreatment. Another ethical aspect of ADs that is currently evolving and to which we have no clear direction as of yet are ADs in respect to incompetent patients and the problems related to determining surrogate decision making. With no clear answers, the primary role of the ICU nurse in this respect would be to provide objective education on ADs to all the parties involved.

What about do-not-resuscitate orders? Are these ADs? That's hard to say. Some sources refer to the do-not-resuscitate order (DNR) as an advance directive; other sources take the position that it is not an AD. Contributing to the ambiguity is the difference between in-hospital and out-of-hospital DNR orders and the variability in state laws. An in-hospital DNR is not an advance directive by the true definition in that it is not a notarized legal document; it is a medical order. The out-of-hospital orders are not so straight forward. Depending on state law, an out of hospital DNR can be a legal document. Either way, DNR orders provide a way for patients to communicate their wishes regarding end of life treatments.

Let's go back to the role of critical care nurses' in ADs.

Critical care nurses have a moral obligation to provide education on advanced care planning and end of life decisions; this includes advance directives. This obligation is imparted upon them by the professional code of ethics, (the American Nursing Association Code of Ethics with interpretive Statements) through very clear language. That said, it's part of the ICU nurse skill set to be prepared to provide this education.

Included in the preparation to provide education is knowing the law. The Patient Self-determination Act of 1991 states health care facilities that receive federal funding are required to ask patients if they have an AD, provide patients with education regarding AD, and the opportunity to obtain an AD. Keep in mind that in addition to this federal law every state has its own law regarding AD. The critical care nurse must know the federal and state law in order to fulfill his or her professional role and moral obligation regarding ADs.

The responsibility to assist patient's with AD is further supported by the ethics surrounding the patient/nurse relationship. Think back to the content on moral accountability. Simply stated the critical care nurse spends the most time with the patient and consequently is in the best position of all the ICU team members to ensure that the patient self-determination act is honored.

One last point. Advance directives are value laden. Culture and religious beliefs influence patients' and families' understanding of death, and dying and this has an impact on the patients'

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and families' understanding of AD. In your professional role as advocate, you must demonstrate cultural sensitivity, and respect for religious beliefs as you educate patients and their families on AD. Furthermore, you must extend this advocacy to include ensuring that other members of the ICU team demonstrate cultural sensitivity and respect for religious beliefs in regards to AD.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 19: Do-not-resuscitate (DNR) principles**

##### **Featuring Melissa**

*Andrew:*

There is a tremendous amount of literature on DNR orders making a comprehensive discussion on DNR orders beyond the scope of this course. However, these orders are an important part of the critical care nurses' practice, so key points will be highlighted.

Although DNR orders have been part of critical care for several decades, there remains a tremendous amount of confusion regarding how these orders are interpreted. This is in large part because of the variability in DNR orders; DNR orders vary in name, how they can be obtained, and how they can be implemented from state to state and even facility to facility. Adding to the confusion is the persistent misconception among the public that a DNR is equivalent to stopping treatment.

*Melissa:*

That is so true and it's not just a misconception amongst the public. I heard so many of my nurses, that I work with on the units saying "Why are we doing this? That patient is a DNR." And that's concerning.

*Andrew:*

Just like other end of life issues, the critical care nurse has a moral obligation to provide patients and families with education on what DNR means and how a DNR order is incorporated into the plan of care. It is imperative that patients and surrogate decision makers understand that requesting that no resuscitative measures be initiated does not mean that treatment of the patient's chronic and acute problems cease.

Included in the education on DNR orders is providing patients with a clear understanding of what resuscitative measures are including the nature and consequences of resuscitative measures. The American Heart Association's guidelines for advanced cardiac life support (including compression, defibrillation, intubation, and emergency medications) provide the framework for this discussion. Lastly, it is also a moral obligation to advocate for patients to ensure that DNR orders are honored or, conversely rescinded when the patient wishes them to be.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 20: Palliative care services – Part 1**

##### **Featuring Melissa**

*Andrew:*

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Another topic that is riddled with confusion is palliative care. Palliative care is a medical specialty that focuses on the holistic care of individuals with serious illness. It concentrates on symptom management or symptom relief, assisting the patient and family manage the stress associated with serious illness, and providing education that enables patients and families to understand the treatment options. The overall goal is to improve or maximize the patient and family's quality of life.

A common misconception is that palliative care is incompatible with curative treatment. This is not the case. Palliative care is not equivalent to end-of-life care. Palliative care, like any other medical specialty, can augment the patient's curative treatment plan and can be part of the patient's treatment at any time during the illness trajectory including the time of diagnosis.

However, should a patient wish to end curative treatment the palliative care service assists the patient in end-of-life decision making and transitions its goals to include EOL care.

*Melissa:*

I did not know that. I thought that palliative care was something that was initiated once curative treatment options had been exhausted and the patient was ready to move towards comfort care and end of life.

*Andrew:*

This does not mean that EOL decisions are made by the palliative care service.

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### **Module 5: Common Ethically Challenging Topics in ICU**

#### **Video 20: Palliative care services – Part 2**

#### **Featuring Melissa**

*Andrew:*

The assistance is limited to providing education and information that enables the patient and family to be fully informed of the nature and consequences of their choices and implementing a plan of care that respects those choices.

This specialty service is available in critical care units either as its own specialty group or as an additional service provided by the critical care team, or as a combination of the two.

Critical care nurses have an important role in palliative care services. As part of your professional duty, you have a moral obligation to advocate for patients they feel would benefit from palliative care services, especially the alleviation of pain. Included in this obligation is a responsibility to correct the common misconceptions that surround palliative care through patient and family education.

Knowing how palliative services are provided in the units is a crucial part of providing patients and families information that is applicable to their situation; therefore, you must familiarize yourself with how palliative services are offered.

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That concludes end of life issues in the ICU. Take this opportunity to reflect on the subject matter and post your reflection in the discussion board. You can watch my interview again if you like. After you've posted, move on to the course wrap up.

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### Course Wrap Up

*Andrew:*

I'll start out by saying thank you. Thanks for your time, attention and willingness to explore health care ethics in the ICU. I hope I was able to provide you with new knowledge and reinforce concepts that you were already familiar with. You're probably wondering why this final message is being delivered via podcast. I'll explain.

To conclude the course, I'd like to guide you through a reflection exercise. I want you to review all the reflections that you've posted throughout the course. While you go over these representations of your thoughts, I want you to look for themes. Concentrate on the image or the words you chose. I want you to look at these reflections without any outside influences. This is why I've chosen not to be seen; I want you to focus on your work. Pause the podcast if you need to. You should be able to find at least one commonality. If you see more that's wonderful. What you've identified is an idea or concept that is important to you – a piece of your value system. That's the take away from this course, a little better understanding of the ethics of the critical care unit and of yourself and the ethic that guides your practice.

Thank you again for your participation. To complete the course go to the next module and complete the course evaluation.

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### Interview 1: Jane RN

*Jane:*

I've been a registered nurse for 38 years, probably 36 of those have been either spent in the ICU or the cath lab. I was working on the floor and I was very frustrated because anytime a patient got really sick and they got interesting, they went to the ICU. And I'm like, okay, this is, floor stuff is boring! I want to go see where, you know, the cool stuff happens. My name is Jane Langley and I'm from New Braunfels, Texas. In my spare time I love to garden, read, and I also do a lot of yoga. I've been interested in yoga since the 1970's. Off and on since then I've continued a yoga practice both on my own and in a guided practice with an instructor. All of the movement of the yoga, all of the asana, and the breathing leads to being able to lie in this resting post where your mind can be empty of thoughts, and if thoughts come into your mind you recognize the thought and then you tell it to move on. So, it leads to an inner peace. How yoga translates to my practice is that if I become flustered or frustrated, I think about that mountain pose I think about getting grounded, taking breaths so that I can calm myself and take stock of what's going on arounds me, and then the meditative post at the end lets me clear my mind. So I can't literally lay down on the floor and relax my whole body, but I can translate that into being at the bedside, being relaxed with the patient, doctor, family and trying to let, not let *my* thoughts intrude but think about what they're saying, what they're doing so I can pay attention to them and not attention to me. I value a holistic approach to patient care. You're not just treating the

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disease process, you're not just treating one disease process, you're not just treating the patient, you're treating the whole patient which includes their spiritual side whether they have an acknowledged spirituality or not and you're also treating all the people that come in contact with the patient. It may be family members, it may be members of their church, it may be friends. But you need to listen to all of those people because they have a link to that patient and the patient has a link to them, and you're trying to become a part of that chain. It's very important to me that what I'm doing is part of the patient and family experience in that I'm receptive to where they are and what's going on with them.

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### **Interview 2: Gabby RN**

*Gabby:*

In my spare time I like to run, exercise, more specifically trail running and adventure races. I like it because it challenges me and it allows me to push myself past my comfort boundaries and really see like what I can do. I always like to take on a challenge, so I'm not intimidated by something that might be really challenging, might intimidating other people I appreciate the challenge and I think it helps me grow. I was attracted to critical care because it was a challenge. It's not always cookie cutter, and sometimes you think you're going one direction and then it ends up being a completely different direction and every day is really a learning, because of those challenges you learn a lot. I enjoy being pushed to my boundaries and then proving to myself that I can go past those boundaries. It's not so much, I don't like to just go for like a little jog. I like to really run and like if it becomes too easy, then its like, what's the next challenge? What's the next thing that I can do that's even more difficult than what I just did? So, like I did half marathons for a while and then I did a marathon because I already felt like I conquered that level. Actually, I got into running because I ran cross country and track in high school. I tried out for the volley ball team, and none of my friends got on the volley ball team and I didn't want to be the only freshman that played volley ball. So, everyone seemed to be doing track so I just did it and I ended up being really good. Like I was a little chubby in high school and everyone was like "this girl's not going to be good at cross country!" My coach actually told me later on that they had bets of like which freshmen were going to do well and which weren't, and no one thought I was going to do well and I ended up being like one of the best freshmen on the team. I actually went into nursing, I didn't have any family that was a nurse, I didn't have any experience, I've never been in a hospital before I started nursing school. But nursing was the most challenging program at the college I went to and I wanted to prove that I could do it. And so that's really why I went into nursing, and it wasn't until I did my first clinical that I was like "wow I actually really love this, I love doing this and being at the bedside." If in my everyday life, if something doesn't challenge me, it's most likely that I'll get bored with it. Especially with our open-heart patients, there's a lot of times that I've told them about my own struggles. And I understand that it's hard for them but I want people to also challenge themselves. And things that are challenging, like for a patient maybe who's diabetic whose culture calls for having a lot of carbs, let's say, and they, they don't think they can do it...and I know it's hard, you know what I mean, I know its hard to change and to meet that challenge but, you know, they have to. So, I try to explain to them that even though it's challenging it's worth it. If you can, if you can meet that challenge it will be worth it. When you think about like, how your talent can relate to your job, and help you in your job I don't think that there's anything better than running because

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running trains you to be able to continue to do your best when you're mentally and physically exhausted. You have to keep going. Right? You have to have the same quality that you put in, in the beginning of your run in the end of your run, or you're not going to do well and the same with nursing. It shouldn't matter if it's the end of a 12-hour shift, maybe three 12-hour shifts in a row and you just gotten the most heavy patient, you know, someone who's very sick. It shouldn't matter you need to give the same quality. Yes, you're exhausted physically, mentally, emotionally, but you have to train yourself to be pleasant and sharp and give it your all, the same quality so I think running has prepared me to do that.

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### **Interview 3: Corey RN**

*Corey:*

When caring for critically sick patients its important to feel calm on the inside. I may not be as calm as I appear, on the inside. But I feel the appearance is important - to be calm. My name is Corey Hooper, I'm from Minnesota and I've been an ICU nurse for about eight years now. In my spare time I like to be in the outdoors, I like to go fishing, and photography and just get outside and away from everything. My photography has to deal with more of getting back to a serene sense for me. Working in the ICU its such a chaotic experience day in and day out, you have to take a break from it. I see that in my work when I'm in a chaotic situation, no matter what's going on I try to keep the situation as calm as I possibly can. With the patient, the doctors the nurses, everybody, all the staff. In a chaotic situation when you're trying to get everything calm and get a harmonious group together with the nurses and the staff and the doctors and with patients and their families as well and I feel when I'm out in the wild, traveling can be a chaotic you know adventure but you have those beautiful serene moments that I try to capture. I got into photography as a way of trying to bring my wife into my adventures. A lot of times she was working and I do these adventures without her and I wanted her to see how beautiful they truly are. In photography its all about the angles, so I have explored different cameras and lately I'm into using drones to find that different angle. I use that [finding the different angle] in the ICU as learning new equipment, and exploring new ways for better care for my patients.

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### **Interview 4: Nannette RN**

*Nanette:*

Well, I originally got started in painting as sort of an empty nest syndrome kind of thing. But it was something I always wanted to do. All my life, I wanted to learn to water color. And so that's kind of what initially opened the door for painting for me was just an empty nest syndrome and trying to you know check off one of those things in life you always wanted to do which was to water color. And so, I went to a Comal County Community Ed class, that was my first water color class. But what has kind of kept me there was that I was totally captivated by it. It was just incredible how an artist could take the ordinary and turn it into the extraordinary with composition and color. And so that's kind of what really, what has kept me there, is the fascination with how, how that artwork can evolve in an artist's hands. I wanted to be that, and I wanted to do that so that's kind of what got me started and like I said, what's had kept me there is that fascination of how. I can see a picture of garden tools you know in the gallery one day,

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and it's just a hoe, a rake, a shovel, and just you know old rusty piece of equipment and yet when I saw it painted through the artist's eyes, the colors they used, the way they laid it, the movement was just, it just fascinated me, it just excited me. And so, that's kind of what, why I got there and why I stay with it, is that fascination. And it became more than that to me, it became, if you were to read my bibliography as an artist, you know I comment about how it helps me to keep my sanity. And it does, you know as a nurse you see so much and dealing with the lives of people and the pain and the suffering that you have to have something, a release, an escape, something to help move you away from that world of nursing back into another perspective, paradigm, someplace in your mind, where you can just clear your mind. And when I get started on a piece like this, I mean, I can start at eight in the morning and suddenly look up and go "on my God, I'm really hungry, it's time to eat lunch, it's one thirty" so I'm totally lost. It takes everything from my mind that goes into that, the concentration, the focus so it's really an extreme mental release. And one of my favorite sayings is from Pablo Picasso, he says that art removes the dust from our soul. That's the purpose of art, to remove the dust from our soul. So, I feel like you know it's removing that dust from my soul and allowing me to clear my mind, clear my soul, and I go back to work refreshed. So that's kind of why I picked are and why I stay with it. Every painting you do is a part of your soul, it's like I showed you earlier my door, my door to success. You know I showed you that painting, and when I painted that it, it was an old craggy door with lots of colors, it's big, it's heavy, I have to open it. I have to get through it, you know it shows that I have to work to get to my success. I think every painting that an artist does takes a chunk of them. You know I paint pictures of my grandchildren, I love my grandchildren, and when I'm painting their picture, that's part of me and how I see them, how I feel them. When I paint a landscaping scene it's got to be something that draws me something that lights a spark in my soul, that I look at it and go "oh you know look at those colors" and that's one of those things you learn as an artist. You become actually more observant and I think I take that back to my work, is my observation skills. Because you know red is not just red, blue is not just blue, a patient's statement is not just a patient's statement. There's more to the story and I think as we become more observant in use of color in our paintings and in subject matter that comes back and we take that to work with us too.

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**Interview 5: Andrew RN**

*Andrew:*

You've heard some of the other critical care nurses share a little piece of themselves as they've gone through their critical care experience and their journeys. So, I'd like to take this time to share my own personal experience in critical care. My faith is very important to me so as I came in one morning to the intensive care unit where I worked, I received report about my patient who was an African American in end stage COPD. And he'd gotten to the point where none of our measures were helping him at all anymore. That was complicated by the fact that he had accepted that he was going to die but his family had not, there was a lot of conflict. I received report that the family members were very angry, some of them were very bitter. What I did not hear in report and I found out later from the providers was that they had shared with our providers that they felt like he was not being given the full opportunity for treatment because he was African American. So that was the situation I walked into unknowingly one morning just knowing that there was conflict. But as I went in that morning, I greeted him, I explained to him

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that I would be taking care of him that day. He was very quiet having trouble breathing and I saw some things in the room that made me wonder if he and I shared the same faith. So, I asked him about his faith. And in a very quiet breathy voice he told me that he did share the same faith that I did. So, as I moved around the room trying to help him get comfortable and reposition him as I gave him his morning medications, I asked him if he would like to hear me sing a gospel song for him, that's one of the things I enjoy doing. He said yes. So, it was just him and me in the room and it was a very private, personal time and so I began to sing *Amazing Grace*. And sometimes I would hum it, sometimes I would sing it. And as I was getting near the end a couple of his family members came in and they sat down and I watched their kind of, their facial expressions change and the room became kind of warm and much more friendly, and I was able to have some good conversations with them about where he was in his disease process. And about the fact that he was getting close to the point that his body was going to pass on. It was a very personal time, it was a very emotional time. What I didn't know was that, that act made all the difference for them as far as feeling like they were cared for, that they were important and that we valued them as people. And it opened up communication lines between the providers, myself, and the family so that when it came time for his passing it was peaceful, it was serene, he was comfortable and the family members were on board with his last decisions.









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