Ethical Competence in Nursing Practice
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To my husband, Hugh,
and my family
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The understanding of ethics is vital to the practice of nursing. This essential and fundamental knowledge guides nurses through their daily practice, yet across the country one sees that ethics education for nurses has often been limited. This book, in its broad scope, addresses ethical concerns through theoretical knowledge, assessment, and skill building within a range of specialty practices, enabling nurses to enrich and develop their critical thinking and ethical competency.

Having a voice in ethical concerns depends on many elements that go far beyond having an opinion. To be heard requires knowledge, self-exploration, dexterity, and a willingness to be fluent in a language of values, meaning, and moral complexity. Nursing is privileged to be grounded in caring and an ethic of care that brings to health systems a valuable perspective as it identifies and discerns how to respond to complex ethical concerns.

This book appears at a time when nurses’ voices in all matters of health care ethics have become increasingly important. Ethical complexities in clinical practice are not new; indeed, a formal Code of Ethics has existed since 1950. It is also true that many nurses, throughout history and in current times, have performed courageous acts of advocacy. However, technological advances are raising new questions, the “bottom line” stretches the seams of our shared work, organizational cultures can be disheartening, and gaps in care continue to plague healthcare systems—all of which profoundly influence the patients’ experiences of care, clinicians’ experiences of providing care, systems that organize care delivery, and the care outcomes (often disparate) that result. The matters and practice of ethics have never been more urgent for nurses and their patients.

Provided with the opportunity to contribute to this collection of thoughtful essays and critically important lessons on ethical competence, we call upon all nurses to strengthen their engagement with ethically complex situations within the context of interdisciplinary, team-based health care. This strong voice requires each of us to reflect on our values, accept responsibility for creating ethical work environments, and attune to our own needs for self-care as we immerse ourselves in a nursing practice that fully embraces ethical complexities.

Values are an inherent part of being human. These ideals organize our daily lives, clarify our decisions, shape our relationships, and contribute to the meaning we derive from our existence. Values emerge from past experiences, influence our current experiences, and often direct our choices about future experiences. Values are personal, but they also seep into our professional lives and merge with our professional standards and codes.
to shape our clinical practice. Occasionally, it behooves us to pause and reflect on our unique kaleidoscope of personal values and professional ethics. This book provides the opportunity to become more thoughtful and knowledgeable about the personal and professional values that guide our daily clinical practice.

The chapters also encourage us to examine and take more responsibility for the conditions in which our nursing practice occurs. Provision 6 in the ANA Code of Ethics (2015) requires us to take action in creating “morally good environments that enable nurses to be virtuous” (p. 23). As nurses, we can no longer afford to be bystanders of climates that normalize “moral muteness” (Verhezen, 2010, p. 180). If there are risks involved in asking important questions that pertain to our care of patients, we must challenge the status quo and transition toward a culture of ethical mindfulness where interdisciplinary, ethics-based conversations become routine and comfortable. Emanuel (2000) noted that ethics is intricately woven into the “webs of interaction” that occur in our systems of care (p. 151). This suggests that relationships are the key to crafting and nurturing ethical cultures.

With that in mind, this book provides philosophical and pragmatic guidance on building relational capacity and communication skills, both of which are essential during team-based ethical conversations. Once these shared deliberations become effective, trust, which forms the foundation of ethical cultures, gradually restructures our systems of care. This transformative change is never easy but seems essential if nurses are to become “full partners with . . . other healthcare professionals in redesigning health care in the United States” (Institute of Medicine, 2010, p. 4).

Finally, self-care is a moral imperative. Provision 5 in our ANA Code of Ethics (2015) refers to “duties to self,” which include attending to not only patients’ health and safety but also our own. An ethical practice of self-care promotes sustainability by addressing the hemorrhaging of individuals—overcome by disengagement, burnout, apathy, and a loss of meaning—from our profession. Care of oneself inoculates nurses in powerful ways to develop resiliency. It is not just the taking care of one’s physical body; it provokes recognition of all the psychosocial and spiritual elements needed for durability in the face of challenges, suffering, injustices, and the demands of service. Even in an ethically sound environment, value differences will give rise to moral distress, which can escalate and exacerbate over time, depleting nurses’ reserves and ability to respond. Ongoing self-assessment, maintaining a plan of self-care, recognizing the potency of healthy boundaries, and the worth of the tend-and-befriend response to stress, all promote commitment to health (Taylor et al., 2000).

Self-care is also practical, because no matter how well we prepare ourselves to deliberate and collaborate in ethically difficult situations, ethical complexities and conflicts that give rise to moral distress will remain a part of clinical practice. The keys are proactively developing a personal and professional resilience plan that includes both maintenance and distress-oriented strategies and then attuning to early signs of distress so the appropriate actions can be taken.

As part of our ethics research, we check in with ICU nurses on a fairly regular basis. At a recent check-in, nurses were debriefing from a very difficult patient situation, and one nurse commented, “I think nursing practice is sacred—not in the sense of religion, but in the sense that we share a sacred time and space with patients and their families. They trust us to do that with them, and as difficult as it is, it is also an incredible privilege.” That speaks to the importance of the lessons in this book. The author has assembled chapters
that provide an opportunity for us all to become more skilled and collaborative in our ethical practices, which, in turn, creates ethical environments that are conducive to our own moral integrity and the practice of safe, high-quality care for patients, their families, and our communities.

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As with most books, the idea for this volume evolved over many years and numerous discussions with staff nurses and educators. Working primarily in adult critical care, I was initially interested in the ability of some nurses to recognize and engage in ethical situations. While other nurses may have identified ethical issues, they often appeared reluctant to initiate or participate in discussions with patient/family members and/or other providers. This reluctance and inaction did not reflect a lack of responsibility or advocacy but seemingly one of sufficient *ethical competence*: the knowledge, skills, and attitudes required to address the many ethical issues that arise daily in nursing practice. Although not as prevalent as it is today, these nurses expressed emotions associated with moral distress such as regret, anger, and thoughts about leaving the profession. This book was written to provide a framework to assist nurses in achieving this ethical competence. It presents a framework that incorporates the cognitive and affective processes that form an understanding of ethical competence in nursing practice: sensitivity, judgment, motivation, and action. Beginning with a brief overview of ethical theories and principles and building on the experiences of readers who are practicing nurses, each chapter includes one or more evolving case scenarios. Questions posed with each case scenario encourage ethical sensitivity, awareness of personal values, and use of a decision-making model that integrates elements of virtue and care ethics. Recognizing the challenges that arise when attempting to implement a justifiable decision, strategies to maintain ethical motivation, or moral courage, are also presented. A distinguished panel of thought leaders and educators in nursing ethics has authored chapters relating to their particular areas of clinical specialty. The content incorporates the American Association of Critical-Care Nurses Essentials of Baccalaureate Education for Professional Nursing Practice, as well as the relevant Institute of Medicine (IOM) and the Quality and Safety Education for Nurses (QSEN) competencies for patient care. The content of the book also incorporates the most updated (2015) version of the Code of Ethics for Nurses. Questions for discussion are included at the end of each chapter as well as PowerPoint slides and additional questions and answers provided for classroom use by instructors. Qualified instructors may obtain access to ancillary materials by contacting textbook@springerpub.com.

Skills to enhance the nurse’s actions in everyday ethical practice with patients, family members, and peers, such as protecting autonomy, promoting safety, and speaking out against lateral violence, are discussed. As the nurse is obligated to maintain and improve...
the moral environment, several chapters discuss the competencies needed to recognize and address organizational and societal issues. Benner (2003) has stated, “It is probably not an exaggeration to say that in every clinical encounter there are ethical issues at the personal, provider, and social levels” (p. 375). While one book cannot encompass all potential situations, our goal is to provide a core framework and useful skills and strategies to actively engage in these issues.

REFERENCE

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Ethical Competence in Nursing Practice
Recognizing and Addressing Moral Distress in Nursing Practice: Personal, Professional, and Organizational Factors

Catherine Robichaux

LEARNING OBJECTIVES AND OUTCOMES

Upon completion of this chapter, the reader will be able to:

- Identify and discuss four responses to ethical situations: moral uncertainty, moral dilemma, moral distress, and moral residue
- Describe personal, professional, and organizational causes of moral distress
- Analyze current interventions and strategies to address moral distress at the personal, professional, and organizational levels

In a 2009 investigation, 71.6% of nurses and physicians from 24 countries reported experiencing an ethical conflict the week before completing the study survey (Azoulay et al., 2009). Current sources of ethical conflict reflect advances in technology, consumers’ expectations of medical care, differing values/goals, poor communication, disruptive provider behaviors, and a business-focused model of health care, among others (Pavlish, Hellyer, et al., 2015). As a nurse, you may encounter such conflicts on a daily basis and believe you know what kind of ethical action is needed, but are unable to act on that knowledge. This inaction may result in feelings of moral distress.
Marcia taught high school math for several years and then received her BSN 2 years ago at the age of 42. Recently, Marcia enrolled in the master in science nurse educator program at a smaller university. This semester, she is taking the clinical practicum course in which she and a faculty preceptor, Ann, have a group of eight senior associate degree students in a 40-bed medical–surgical unit. One of the students, Jackie, has been having difficulty in both the clinical and didactic components of the course and is often late in the morning and for clinical conferences. Marcia has recently observed Jackie conducting a very superficial physical assessment and documenting inaccurate findings in the patient’s electronic record. When she attempts to discuss this situation with her, Jackie states, “You have no authority over me; you’re just a student, too!” Although Ann, the faculty preceptor, had Jackie repeat the physical assessment and correct her charting, Jackie continues to take shortcuts and narrowly avoids making a medication error on the following clinical day. Marcia decides to discuss her concerns regarding Jackie’s competence and professionalism with Ann, who says “I agree, but she has been passed along by the other faculty and is about to graduate. The former dean didn’t want to lose any more students from the program and I’m not sure about the new dean. In addition, Jackie works nights right now and is the main provider for her three kids. She really needs a better job, like nursing.” Marcia considers Ann’s comments and thinks, “Well, I am just a student in this program and I don’t want to get in an argument with the dean or ruin Jackie’s chance for a career, but what if she continues to be unsafe?”

Marcia is both a student and a practicing nurse who has a primary professional obligation to protect patients; however, she does not want to harm her own career by potentially angering the dean of the school in which she is a student. Marcia is also concerned that the university faculty “passed along” Jackie and believes it should have been their responsibility to take action sooner in the program. She does not want to jeopardize Jackie’s future and ability to care for her family, but is aware of Provision 3 of the Code of Ethics: “The nurse promotes, advocates for, and protects the rights, health, and safety of the patient” (ANA, 2015a, p. 9). In addition, Statement 3.3 mandates: “Nurse educators, whether in academics or direct care settings, must ensure that basic competence and commitment to professional standards exist prior to entry into practice” (p. 11). As the practicum continues, Jackie’s clinical skills and didactic performance remain marginal and Marcia begins to have headaches and bouts of sleeplessness. Marcia is experiencing moral distress, described as the psychological, emotional, and physiological suffering that nurses and other health professionals endure when they act in ways that are inconsistent with deeply held ethical values, principles, or commitments (McCarthy & Gastmans, 2015). Another definition proposes that moral distress is “mental anguish as a result of being conscious of a morally appropriate action, which despite every effort cannot be performed owing to organizational or other constraints” (Schluter, Winch, Holzhauser, & Henderson, 2008, p. 306).
Despite its apparent prevalence across nursing specialties and among all health care disciplines, both nationally and internationally, moral distress remains a contested concept. For some, the notion of moral distress remains ambiguous and they maintain that further examination will not contribute to quality deliberation or ethical nursing practice (Johnstone & Hutchinson, 2015; Pauly, Varcoe, & Storch, 2012). Others propose that inattention to moral distress among nurses and other providers will continue to result in burnout and/or leaving the profession (Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015). To bridge this gap, Peter (2015) suggests that our understanding of moral distress has expanded and may serve as a window through which nurses and others can describe the nuances of their ethical experiences. She proposes that perhaps “we have asked too much of this concept [moral distress] by attempting to articulate more about the nature of nurses’ ethical lives than it can reliably hold” (p. 3). Although recognition of moral distress is essential, developing and implementing interventions to reduce its impact is critical. Thus, the purpose of this chapter is to describe the origins of moral distress, its contributing factors, and potential interventions designed to mitigate its deleterious effects on ethical nursing practice.

RESPONSES TO ETHICAL SITUATIONS

Question to Consider Before Reading On

1. How would you describe Marcia’s initial responses in this situation?

As initially described by philosopher Andrew Jameton in his book, Nursing Practice: The Ethical Issues (1984), and experienced by Marcia in the Case Scenario, moral distress can occur when a nurse or other provider believes he or she knows what ethical action is needed but is unable to act on that knowledge. Recall that in Chapters 1 and 2 we discussed Rest’s four-component model (FCM, 1986) for developing ethical skills or competence in nursing practice: sensitivity, judgment, motivation, and action. Moral distress inhibits or impedes motivation, resulting in inaction. This response to an ethical situation differs from other reactions described by Jameton (1984) and Rushton & Kurtz (2015), moral/ethical uncertainty, dilemmas, and conflicts, presented in Box 4.1.

Case Scenario (continued)

If Marcia were unsure whether the situation with Jackie constituted an ethical issue or did not understand which ethical principles or provisions/statements from the Code of Ethics were relevant, she would be experiencing moral uncertainty. This uncertainty may be the result of lack of sensitivity or ethics.
Case Scenario (continued)

education and there may be no resolution of the issue. However, Marcia may still experience emotional or physical symptoms that suggest something is “not quite right” and continue with ethical deliberation and action as presented in the FCM.

Box 4.1

Responses to Ethical Situations

Moral uncertainty—uncertainty about which ethical principles and/or provisions from the Code of Ethics apply in an ethical situation.

Moral dilemma—two ethically viable principles or goals are in opposition to each other in an ethical situation and only one may be chosen.

Moral conflict—stakeholders in an ethical situation have opposing views about how it should be resolved.

Moral distress—a nurse or other provider believes he or she knows what ethical action is needed but is unable to act on that knowledge.

Moral residue—painful feelings that remain after experiencing morally distressing situations.

Sources: Jameton (1984); Rushton and Kurtz (2015).

As discussed in Chapter 1, an ethical or moral dilemma occurs when there are two competing principles or values that are in opposition to one another. While each option may be ethically viable, only one may be chosen and the nurse may feel that he or she is compromising one value for another. Nursing care situations in which patient autonomy may be compromised to maintain safety and prevent harm are examples of possible ethical dilemmas. Differing values or goals of the organization may also conflict with those of the nurse or other provider. In the Case Scenario, Marcia may feel that her core values of protecting patients and maintaining professional standards conflict with the educational institution’s goal of retaining students.

Providers and others involved in an ethical dilemma may have opposing views about how the situation should be resolved, resulting in moral conflict. As Rushton and Kurtz (2015) observe, conflicts generally arise over disagreements about the goals of care or perceived treatment outcomes. They describe resuscitation status as a decision that may result in conflict among or within health care team members and the patient/family. The decision to resuscitate...
extremely premature infants provides an example of this potential moral conflict (Molloy, Evans, & Coughlin, 2015). Those involved in the decision may have differing opinions regarding whether the benefits of resuscitation outweigh the risks of possible long-term health issues and compromised quality of life for the infants and families. The intensely emotional nature of such conflicts makes reasoning very difficult. In the communication process necessary to address these ethical conflicts, it is critical that those involved are not required to abandon their core values or professional integrity.

Questions to Consider Before Reading On

1. How would you define moral distress?
2. Do you believe you have experienced moral distress?
3. How did you learn to deal with it in your initial nursing program or in continuing education since you graduated?

DEFINING MORAL DISTRESS

In describing the origins of the concept of moral distress, Jameton (2013) discusses the introduction of bioethics courses in medical school curricula in the 1970s and 1980s. Faculty teaching these courses recognized that nurses and nursing students were very interested in the study of ethics and, consequently, the courses were offered campus wide. Although often labeled “medical ethics,” many more nurses enrolled in these courses than students in other health care professions. While faculty had previously taught major ethical theories and representative dilemmas that highlighted the central role of the physician, the predominance of nurses in the classroom shifted that focus. As a result, Jameton notes, Davis and Aroskar published one of the first modern nursing ethics books in 1978, Ethical Dilemmas and Nursing Practice.

Jameton (2013) observes that nurses in the ethics courses discussed concerns that were practical and relational in nature. As the time period (1970s–1980s) coincided with a beginning interest in feminism and feminist ethics, these concerns also included issues of powerlessness, inequality, and bureaucratic constraints on ethical nursing practice. Although many students had several years of clinical experience, Jameton states “they expressed little confidence in their own views” on ethical issues and expected to “receive little support from physicians or nursing administrators” (p. 298). The concept of moral distress then appeared to represent a more comprehensive depiction of nurses' moral problems and challenges.

While the original definition of moral distress is credited to Jameton (1984), both he and Fowler (2015) maintain that Kramer’s 1974 work on reality shock in nursing predates his identification of the phenomenon. Kramer’s seminal research explored the transition of recently graduated nurses into the workforce and “the discrepancy and shock like reactions that follow”
When they realized that their professional values and identity were not congruent with or supported by the immediate practice environment and/or employing organization. Given the increasing complexity of the current health care environment, many contend that this reality shock continues and is perhaps even more serious today (Dyess & Sherman, 2010; Kramer, Brewer, & Maguire, 2013). This experience of reality shock is reflected in Jameton’s definition of moral distress, “one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). As Epstein and Delgado (2009) observe, with moral distress, the appropriate or right action has been identified and discussion of the precipitating ethical situation is less critical. Rather, addressing moral distress requires consideration of both personal and professional factors and identification of organizational constraints.

### Causes of Moral Distress

#### Personal and Professional Factors

While Jameton’s original definition of moral distress focused on organizational constraints on moral action, others propose that personal factors also hinder ethical practice (Epstein & Hamric, 2009; Rushton & Kurtz, 2015; Webster & Bayliss, 2000). In addition to those personal characteristics and internal constraints discussed in Chapter 2, such as individual values, protecting one’s position, or lack of ethical sensitivity, these authors include perceived powerlessness, past experiences, and emotional stability.

#### Perceived Powerlessness

The often hierarchal nature of the health care system contributes to power differentials based on whose work may be considered more important (Pavlish, Brown-Saltzman, et al., 2015). As a result, nurses may feel that they have little influence on directing patient care or on decision making in general. Implementing the decisions of others while lacking authority and experiencing increased responsibility may contribute to moral distress. In the Case Scenario, Marcia may feel powerless as she is “just a student” and has to adhere to the decisions of the dean and faculty while feeling responsible for the impact of Jackie’s incompetence on present and future patient care.

#### Past Experiences

In studies exploring moral distress in nursing, several researchers found that those who had been in practice for a longer period experienced more moral distress than those newer to the profession (Epstein & Delgado, 2010; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2015). As those past experiences causing moral distress may recur, nurses can have a “here we go again” response.
associated with dread, helplessness, and disengagement. These recurrent ethical situations may or may not be resolved and the painful feelings linger, resulting in moral residue. As defined by Webster and Bayliss (2000), moral residue is “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised” (p. 208). Frequent situations associated with moral distress and residue include providing aggressive, prolonged futile care, working with incompetent clinicians, and conflicts with other health care providers (Hamric, Borchers, & Epstein, 2012; Sauerland et al., 2014, 2015; Whitehead et al., 2015).

While nurses and other providers who have been practicing longer may have higher levels of moral distress, those newer to the profession may also be susceptible to its damaging effects. Indeed, the resulting “reality shock” and moral distress experienced by novice nurses have been identified among undergraduate nursing students who report witnessing poor nursing practice and experiencing bullying from preceptors (Grady, 2014; Sasso et al., 2015; Yoes, 2012). Students and recent graduates may not have sufficient experience and coping skills to address such morally distressing situations and/or may not be aware of existing resources to assist them.

**Emotional Stability**

Rushton and Kurtz (2015) state that a nurse’s ability to remain mentally and emotionally stable in morally distressing situations may also be a factor in his or her experience of moral distress. Feeling helpless or unable to act in these circumstances can initiate stress responses such as “fight (anger), flight (abandonment), or freeze (numbing)” (p. 13). The fact that nurses are expected to be stoic and endure without overt reaction may add to these overwhelming...
stress responses. The experience of emergency department (ED) nurses working in resuscitation rooms provides a graphic example of struggling to maintain emotional control in these situations.

Houghtaling (2012) describes the moral suffering of nurses in the ED, who often witness unnecessary suffering and must perform painful procedures while “literally holding themselves together”: “When seconds are all these nurses have, there is no time to premeditate or look inward; they must perform—whether or not they agree with the care practices that are carried out in the situation immediately unfolding around them” (p. 235). The stress and pressure to endure in such scenarios may cause the nurse to vent his or her frustration on another staff member and/or experience moral distress and moral residue. Houghtaling suggests that when nurses learn to recognize highly volatile and morally, ethically charged dilemmas, they may become more effective in finding skills within themselves to maintain a sense of well-being and balance. Strategies to increase resilience and mental/emotional stability when experiencing moral distress are discussed in the section on addressing moral distress.

Organizational Factors

Question to Consider Before Reading On

1. How would you describe the ethical climate in the organization in which you currently work or have worked in the past?

Ethical climate is described as the organizational conditions and practices in which problems with ethical implications are identified, discussed, and decided (Olson, 1998). As discussed in Chapter 2, moral distress can be exacerbated in organizations with a deficient ethical climate. Fear of reprisal for actions and/or limited access to ethics resources when dealing with ethical situations can result in moral distress. Additional institutional factors include lack of ethical, supervisory support, inadequate and/or incompetent staff, excessive workloads, and bullying, lateral violence, incivility, and workplace violence (Hamric, 2014; Whitehead et al., 2015). These organizational influences may create sources of moral distress and inhibit its resolution. Several of these factors are discussed in more detail as follows.

Lack of Ethical, Supervisory Support

Question to Consider Before Reading On

1. What level of ethical, supervisory support have you received where you are currently employed or have been employed in the past?

Effective, supportive leadership is essential to ethical nursing practice and is associated with a healthy work environment, improved patient safety and satisfaction, and decreased nurse turnover (Laschinger & Smith, 2013; Zook,
Lack of such leadership can contribute to or directly cause moral distress (De Veer, Francke, Struijs, & Willems, 2013; Galletta, Portoghese, Battistelli, & Leiter, 2013). As noted previously, if the nurse feels that he or she will not be supported when speaking up in an ethical situation, patient safety may be compromised and nurse moral integrity impaired.

While supportive, ethical leadership has been examined extensively in the business literature, it has received far less attention in nursing (Makaroff, Storch, Pauly, & Newton, 2014; Storch, Makaroff, Pauly, & Newton, 2013). Although leadership theories discussed in nursing contain moral components and behaviors, ethical leaders focus explicitly on ethical obligations and guidelines and hold others accountable to do the same. Thus, their potential impact goes beyond simply increasing sensitivity to ethical issues and standards. Peers and employees trust ethical leaders and display more positive attitudes and greater job performance because of this heightened trust. In addition, these nurse leaders may influence the ethical conduct of others by modeling critical thinking and action regarding situations with ethical content (Zheng et al., 2015). The importance of ethical, supervisory support and leadership to ethical nursing practice is discussed more fully in Chapter 10.

**Case Scenario (continued)**

Returning to the Case Scenario, Marcia and Ann arrive for their appointment with the dean of the nursing school and are escorted into her office. Marcia describes their concerns regarding Jackie’s clinical competence and lack of attention to constructive feedback from both her and Ann. Marcia shares her distress regarding possibly jeopardizing Jackie’s future but believes it is a professional, ethical responsibility to share their assessment. Dr. B, the dean, thanks Marcia and Ann for coming forward with their honest appraisal. She continues by adding that nurses in all roles, including education, administration, and research, share the primary, ethical commitment of providing high-quality care to the patient. Dr. B then refers to interpretive statement 7.3 in the Code of Ethics (2015a), “Academic educators must also seek to ensure that all their graduates possess the knowledge, skills, and moral dispositions that are essential to nursing” (p. 28). Dr. B states that she, Marcia, and Ann will meet with Jackie to discuss her continued progression in the program. She also notes that, as contained in the undergraduate student handbook, students who have a documented pattern of unsafe or unprofessional clinical performance and have not improved following remediation may not be permitted to repeat the course. After leaving the dean’s office, Ann thanks Marcia for arranging the appointment and states, “I feel more supported now in making these difficult decisions about students.”
PART II  ■  Skills and Resources for Ethical Decision Making

Inadequate and/or Incompetent Staff

Questions to Consider Before Reading On

1. Have you ever worked with incompetent staff?
2. What was the outcome?
3. Use the Box 4.2 to assess any personal, professional, or organizational factors that are present where you are employed that may lead to moral distress.

Several studies that have used the original Moral Distress Scale (MDS; Corley, Elswick, Gorman, & Clor, 2001) or the revised version (MDS-R; Hamric et al., 2012) or a qualitative, open-ended survey reported that nurses and other providers identified working with inadequate and/or incompetent staff as both highly distressing and occurring frequently (Sauerland et al., 2014, 2015; Wilson, Goettemoeller, Bevan, & McCord, 2013). In addition, research participants described providers who offered less than optimal treatment that did not meet the standard of care, witnessing poor patient care because of inadequate staff communication. Despite the prodigious amount of research documenting the direct relationship between inadequate registered nurse staffing and poor patient outcomes and increased mortality, this issue remains an ongoing concern (Dent, 2015; Needleman, 2015; West et al., 2014). As discussed in Chapter 10, the American Nurses Association (2012) and several specialty organizations (Thompson & Davidson, 2014) have proposed guidelines and strategies for adequate and competent nurse staffing. In addition, federal legislation regarding safe nurse staffing is presently under review in the U.S. Senate (Registered Nurse Safe Staffing Act of 2015).

Continued work is needed to develop an optimal staffing model that integrates site specific variables such as acuity, provider preparation, and the relational work of nursing, among other factors (Malloch, 2015; Needleman, 2015). As Malloch observes, much of the work of nursing is relational and therefore difficult to measure and integrate in a staffing model. In addition, nursing requires critical thinking, the synthesis of disparate data items, teamwork coordination around episodes of patient care, and ensuring safe navigation through the health care system. This complexity requires not only innovative measures, but new classifications of the work of nursing (Archibald, Caine, & Scott, 2014). Meanwhile, nurses may remain caught between their obligations to care for a potentially unsafe number of patients and maintaining their professional and ethical integrity. The Code of Ethics (2015a) is explicit in identifying the frontline nurse and nurse administrator’s responsibility to take action in situations of incompetent or unsafe care (Box 4.2). Developing and contributing to moral environments that support and encourage such action is essential to ethical practice.
Recognizing and Addressing Moral Distress in Nursing Practice: Personal, Professional, and Organizational Factors

Relevant Provisions and Selected Statements from the Code of Ethics (2015a)

**Provision 1**

**Interpretive Statement 1.5**

**Relationship With Colleagues and Others**

Respect for persons extends to all individuals with whom the nurse interacts. Nurses maintain professional, respectful, and caring relationships with colleagues and are committed to fair treatment, transparency, integrity preserving compromise, and the best resolution of conflicts. The nurse creates an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect. This standard of conduct includes an affirmative duty to act to prevent harm. Disregard for the effects of one’s actions on others, bullying, harassment, intimidation, threats, and violence are always morally unacceptable behaviors.

**Provision 3**

**Interpretive Statement 3.5**

**Protection of Patient Health and Safety by Acting on Questionable Practice**

Nurses must be alert to and must take appropriate action in all instances of incompetent, unethical, illegal, or impaired practice or actions that place the rights or best interests of the patient in jeopardy.

**Provision 4**

**Interpretive Statement 4.4**

**Assignment and Delegation of Nursing Activities or Tasks**

Nurses in management and administration have a particular responsibility to provide a safe environment that supports and facilitates appropriate assignment and delegation. This includes orientation, skill development; licensure, certification, continuing education, competency verification; adequate and flexible staffing; and policies that protect both the patient and the nurse from inappropriate assignment or delegation of nursing responsibilities, activities, or tasks.

(continued)
Recognizing and Addressing Moral Distress in Nursing Practice: Personal, Professional, and Organizational Factors (continued)

**PROVISION 5**

**INTERPRETIVE STATEMENT 5.2**

**PROMOTION OF PERSONAL HEALTH, SAFETY, AND WELL-BEING**

Fatigue and compassion fatigue affect a nurse’s professional performance and personal life. To mitigate these effects, nurses should eat a healthy diet, exercise, get sufficient rest, maintain family and personal relationships, engage in adequate leisure and recreational activities, and attend to spiritual or religious needs.

**INTERPRETIVE STATEMENT 5.4**

**PRESERVATION OF INTEGRITY**

When the integrity of the nurse is compromised by patterns of institutional behavior or professional practice, thereby eroding the ethical environment and resulting in moral distress, nurses have an obligation to express their concern or conscientious objection individually or collectively to the appropriate authority or committee. Nurse administrators must respond to concerns and work to resolve them in a way that preserves the integrity of the nurses. They must seek to change enduring activities or expectations in the practice setting that are morally objectionable.

**PROVISION 6**

**INTERPRETIVE STATEMENT 6.2**

**THE ENVIRONMENT AND ETHICAL OBLIGATION**

Nurses in all roles must create a culture of excellence and maintain practice environments that support nurses and others in the fulfillment of their ethical obligations.

Many factors contribute to a practice environment that can either present barriers or foster ethical practice and professional fulfillment.

Source: ANA (2015a).

**Bullying, Lateral Violence, Incivility, and Workplace Violence**

**Question to Consider Before Reading On**

1. What types of bullying, lateral violence, incivility, and/or violence have you witnessed or experienced in your work place?

Rushton and Kurtz (2015) suggest that nurses’ support or lack of support for one another can affect the level of moral distress in the health care environment.
The complexity of patient care demands that all health care professionals work together collaboratively as a team; however, that is often not the reality. The old adage of “nurses eat their young” still exists and, sadly, remains quite robust. Indeed, the health care professions have one of the highest levels of bullying in the workplace (Farouque & Burgio, 2013) and with incivility, and lateral violence behaviors, contribute to and result in moral distress. It is difficult to find a recent professional journal in any health care discipline that does not contain an article on these and other disruptive behaviors, their effects on the quality of patient care, and the morale of providers (Fink-Samnick, 2015; Troxman, 2015; Van Norman, 2015).

The terms bullying, lateral or horizontal violence, and incivility are often used interchangeably. Although there are commonalities among these behaviors, there are also differences. Bullying is repeated, long-term, health-harming mistreatment of one or more persons by one or more perpetrators and is marked by behavior that is threatening, humiliating, or intimidating. Bullying can be a reflection of the hierarchal system in health care and other organizations in which those who occupy higher levels or are more experienced bully individuals who are new and/or at lower levels. Recent graduates continue to be victims of bullying despite overwhelming evidence that these behaviors contribute to moral distress, turnover, and leaving the profession. In addition, as seen in Box 4.2, bullying and other destructive conduct are a direct violation of the Code of Ethics and countermand Quality and Safety Education for Nurses (QSEN) competencies associated with teamwork and collaboration (Box 4.3).

Lateral or horizontal violence is described as “Unkind, discourteous, antagonistic interactions between nurses who work at comparable organizational levels and commonly characterized as divisive backbiting and infighting” (Alspach, 2007, p. 13). While behaviors associated with lateral violence, such as sarcastic comments and withholding support, are similar to those used in bullying, the perpetrator and victim are at comparable levels in the organization or unit.

The prevalence of bullying and lateral violence behaviors in nursing has been attributed to prior victimization and oppressed group theory, among other reasons. Being the recipient of such destructive conduct may cause the nurse to retaliate in kind with a peer or other employee, thus continuing the cycle of victimization and moral distress. Oppressed group theory proposes that people who are victims of a situation of dominance turn on each other rather than confront the system, which oppresses them both. If the nurse in these situations is unable to speak up because of fear of retribution and is forced to work under such duress, he or she may experience moral distress. Dellasaga and Volpe (2013) note that those who repeatedly witness bullying and lateral violence may also experience moral distress if they are reluctant to intervene for fear of becoming a victim themselves.

Disrespectful and uncivil interactions in health care not only contribute to an unethical, morally distressing environment but also jeopardize patient safety. For example, a new graduate makes a medication error because he or
she did not want to clarify the dosage with his or her preceptor for fear of being ridiculed again. Dr. R. continually berates and intimidates the perioperative staff, “fostering an atmosphere in which medical errors become more likely and interpersonal interactions erode the primary goal of putting the patients’ welfare foremost” (Van Norman, 2015, p. 215). Studies have reported startling statistics indicating a direct relationship between these egregious behaviors, adverse events, and staff turnover. In Rosenstein’s (2010) survey of over 4,500 respondents (nurses, physicians, pharmacists, and administrators) from more than 100 hospitals, 67% identified a strong relationship with adverse event occurrence, while 27% felt that the behaviors contributed to patient mortality. Rawson, Thompson, Sostre, and Deitte (2013) estimated that in a 400-bed hospital, the combined costs of disruptive physician behaviors resulting in staff turnover, medication errors, and procedural errors exceeded $1 million annually. According to a recent national survey (Nursing Solutions Incorporated, 2016), the average cost of turnover for a bedside registered nurse ranges from $37,700 to $58,400, resulting in the average hospital losing $5.2 million to $8.1 million.

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as those physically and psychologically damaging actions that occur in the workplace or while on duty (2002). Although often discussed in the same context as bullying, lateral violence, and incivility, workplace violence includes actions perpetrated by patients and/or family members. The findings of an American Nurses Association (ANA) survey of 3,765 registered nurses and nursing students demonstrate evidence of the prevalence of these behaviors committed by those to whom we provide care.

Source: AACN (2012); Cronenwett et al. (2007).
Forty-three percent of the respondents reported having been verbally and/or physically threatened while 24% had been physically assaulted by a patient or family member of a patient in the previous 12 months (ANA, 2014). That these behaviors are considered endemic in certain settings such as EDs and psychiatric units suggests “that workplace violence is a culturally accepted and expected part of one’s occupation” (ANA, 2015b).

There has been a great deal of research on moral distress across health care disciplines (Whitehead et al., 2015). It has been identified as a reality of nursing practice that is not going away (Rushton & Kurtz, 2015). Development of evidence-informed interventions to address its often deleterious effects, however, remains ongoing. Although nurses and other providers may be familiar with the feelings associated with moral distress, they may not be aware of the term itself. Consequently, recognition and labeling of the experience is an initial first step toward implementing any intervention. As one nurse shared in a recent study, “When I first joined the NEC (Nursing Ethics Council), I had no idea how to define moral distress. Now, I am more vigilant about situations that can cause moral distress, seek to address those situations early, and try to act as a resource for my peers.” (Sauerland et al., 2015). The NEC mentioned by this nurse is part of a multilayered approach initially discussed in Chapter 2. In conjunction with developing ethical skills, this approach also has relevance in addressing moral distress. The personal and professional causes of moral distress were identified in addition to organizational sources. The following section will discuss building competencies at each level to address moral distress.

Personal and Professional Competencies

**Ethics Education**

**Questions to Consider Before Reading On**

1. What types of formal or continuing education have you had in ethics?
2. What resources do you have to turn to when you experience moral distress?

The necessity of ethics education for nurses is well documented and has been shown to influence moral confidence and action (Grady, 2014; Laabs, 2015; Witt, 2011) and decrease moral distress (Robinson et al., 2014). The inclusion of a specific course on ethics in undergraduate or master’s programs, however, does not universally exist (Bartlett, 2013). While some programs do have identified ethics courses, others “integrate” content across curricula which, as Rushton observes, “means that it can be pretty invisible” (as quoted in Der Bedrosian, 2015). In addition, current didactic approaches to teaching ethics content may not prepare students to recognize day-to-day ethical issues and engage in problem solving. Krautscheid and Brown (2014) reported that
senior baccalaureate students were unable to recall or apply principles presented in an ethics course to a simulated medication safety scenario. Rushton (as quoted in Der Bedrosian, 2015) states that nurses’ potential, inadequate ethics preparation is exacerbated by a lack of continuing education opportunities in ethics. As a result, nurses may be challenged to “demonstrate ethical competence in professional life” (p. viii) as directed in the Code of Ethics (ANA, 2015a).

It may not be necessary to have extensive knowledge regarding ethical terms, theories, and principles. However, nurses should have an adequate understanding of these components to be able to identify and engage in situations with ethical content from the day-to-day issues or “microethics” to those more complicated. Frequently, nurses believe they have this understanding when in actuality they are referring to their morality (i.e., they are good people who were raised well, have values, and can therefore make appropriate ethical decisions). While an understanding of personal values is essential, it is not sufficient for ethical practice. Although the terms “ethical” and “moral” are often used interchangeably in this book, Klugman notes an important distinction between ethics and morality, stating that the latter is sometimes “irrational and illogical” (Chapter 1). Chapter 1 also provides an overview of ethics terms, theories, and principles needed to initiate and participate in ethical discussions, including those causing moral distress.

Recognizing that additional education in ethics and moral distress may be beneficial, the individual nurse can take advantage of material offered by professional organizations such as the ANA. Resources available on the ANA website “Ethics” tab include several articles on moral distress and moral courage in addition to position statements on end of life and other ethical issues of concern to nurses (2016a). The American Association of Critical Care Nurses (AACN) identifies addressing moral distress as a strategic initiative in creating a healthy workplace environment. The organization has issued a position statement on moral distress (AACN, 2012) and developed a handbook, The 4 A’s to Rise Above Moral Distress: Ask, Affirm, Assess, and Act (2004). The three-part Moral Distress Education Project at the University of Kentucky (2015) is a free, multimedia CE program that provides an overview of the root causes of moral distress and presents strategies to prevent its recurrence.

Reading and discussing articles related to ethics such as those contained in the references in this book is another approach to enhancing ethical skills and competence. As mentioned earlier, forming a nursing ethics group or committee and conducting interdisciplinary or nursing ethics rounds may provide opportunities to identify and clarify issues with ethical or nonethical content. The author participates in a NEC at University Health System in San Antonio, Texas. The council, which meets monthly, serves as a supportive environment for discussion of ethical issues pertinent to nurses and provides opportunities for ethics education.
Effective Communication and Conflict Engagement Competencies

Questions to Consider Before Reading On

1. How do you usually respond when faced with moral distress or conflict?
2. Does this work for you?
3. How would you improve these skills?

Baccalaureate essential VI states that the nursing program prepares the graduate to “Incorporate effective communication techniques, including negotiation and conflict resolution to produce positive professional working relationships” (AACN, 2008, p. 23). These skills are also considered essential QSEN competencies, as presented in Chapter 2. Despite these mandates, new graduates and experienced nurses continue to be described as lacking assertive communication skills and using avoidance when confronted by conflict (Pavlish, Brown-Saltzman, et al., 2015; Theisen & Sandau, 2011). We continue to hear about the detrimental effects of conflict avoidance and overall poor communication among health care team members and the impact on patient safety and mortality (Okuyama, Wagner, & Bijn, 2014; Sayre, McNeese-Smith, & Leach, 2012). More than 15 years after the Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Health System* (1999), and the follow-up report, *Crossing the Quality Chasm* (2001), and following national ongoing initiatives from The Joint Commission (2015) and the Institute for Healthcare Improvement (2013a, 2013b), little progress has been reported in improving quality and safety (Dolansky & Moore, 2013; Rainer, 2015).

As a result of this lack of improvement, several programs have been developed to strengthen communication and conflict resolution skills and perhaps decrease the incidence of moral distress among health care providers. Crucial conversations training (Patterson, Grenny, McMillan, & Switzler, 2011), discussed in Chapter 2, has been shown to specifically increase perioperative nurses’ ability to address physicians’ disruptive behaviors (Saxton, 2012). The program has been implemented successfully in several health care organizations, including Spectrum Health in West Michigan and Maimonides Medical Center in Brooklyn, New York. Results indicated that, after crucial conversations training, nurses and staff members addressed issues and concerns with one another instead of relying on managers and there was a 39% improvement in confronting violations of respect (VitalSmarts, 2015). Additional communication and conflict engagement skills include elements of TeamSTEPPS (AHRQ, 2016; Harvey et al., 2013) and cognitive rehearsal (Griffin, 2004; Griffin & Clark, 2014). These skills are based on scripting and require actual practice, as with developing any technical competency. Ideally, they should be practiced in a group setting using role play but can also be applied by the individual nurse.

Cognitive rehearsal is an evidence-based strategy used in behavioral health that involves memorization, learned, although not by rote, of a thought or an
expression “designed to help an individual cue a certain behavior or express a desire to others” (Glod, 1998, pp. 58–59, as quoted in Griffin & Clark, 2014, p. 540). This strategy can take several forms and be used to address common, uncivil behaviors and/or patient safety and conflict situations. Table 4.1 lists several common uncivil behaviors and associated cognitive rehearsal responses. Being able to recall these responses may allow the nurse to address the behavior or situation in the moment rather than experiencing anger and/or regret later for not speaking up.

The “CUS” technique and “DESC” scripting methods associated with TeamSTEPPS (AHRQ, 2016) are variants of the cognitive rehearsal strategy. CUS, an acronym for concerned, uncomfortable, and safety, is an assertive communication technique used when a patient safety issue or change in status is identified and can also be used to address uncivil behaviors. For example, the CUS technique can be applied in the following way: “Dr. Smith, I am concerned about Mr. Brown’s rapid increase in heart rate. I am uncomfortable with his change in status. I don’t think this it is safe for him to be unmonitored.” Similarly, a nurse may respond to a bullying or lateral violence

<table>
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<tr>
<th>Table 4.1</th>
<th>Uncivil Behaviors and Cognitive Rehearsal Responses</th>
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<tbody>
<tr>
<td>Nonverbal behaviors (sighing, eye rolling, etc.)</td>
<td>“I sense from your expression that there is something you wish to say to me. Please speak directly to me.”</td>
</tr>
<tr>
<td>Spreading rumors, gossiping, sabotaging</td>
<td>“I don’t feel right talking about him/her/situation when I wasn’t there. I suggest you speak directly to them.”</td>
</tr>
<tr>
<td>Using silent treatment or withholding information</td>
<td>“I understand that there was more information about this patient/situation. Please share all relevant information as safe patient care depends on collaboration.”</td>
</tr>
<tr>
<td>Sarcastic comments, yelling, demeaning remarks</td>
<td>“I do not appreciate your comments/yelling as it is unprofessional behavior. If there is something you wish to discuss with me, we can do so privately.”</td>
</tr>
<tr>
<td>Distracting, disruptive behaviors, inattention during handovers/meetings</td>
<td>“Can I speak with you about your conduct in handovers/meetings? It is distracting and may jeopardize patient care/effective communication.”</td>
</tr>
</tbody>
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Sources: ANA (2012); Griffin (2004); Griffin and Clark (2014).
experience by saying, “I am concerned about your uncivil tone. I am uncomfortable and stressed by this unprofessional situation which makes it difficult to work together and provide safe patient care.”

The DESC communication model is used in TeamSTEPPS and described as “carefronting” by Briles (2007). The DESC acronym refers to describe the behavior/situation, explain the effect of the behavior/situation, state the desired change or outcome, and consequences, or what will happen if the behavior/situation continues. It is an assertive but caring technique based on work by Augsberger (1973), a family therapist, and adapted to nursing by Kupperschmidt (1994, 2006, 2008). Carefronting is similar to having a crucial conversation in that it involves holding someone accountable by confronting them in situations involving disrespect and/or those jeopardizing patient safety. Nurses have reported experiencing moral distress and remorse when they are unable to speak up and get others to listen to them or respect their opinions (Maxfield, Greeny, Lavandero, & Groah, 2011; Maxfield, Lyndon, Kennedy, O’Keefe, & Zlatnik, 2013). The goal of all these techniques is to develop an ethical environment based on mutual respect in which providers can work together to provide safe patient care. Kupperschmidt (2008) notes that carefronting is honest, courageous communication that requires courage (Chapter 2) and rigor. She states that rigor “means having the discipline to plan for effective carefronting: to make optimal use of resources, to say what one will do, and to do what one says. We cultivate rigor, and thus courage, by putting personal convenience in perspective, letting logic prevail, and ensuring that we are not blaming and shaming” (p. 15). Box 4.4 provides an example of a carefronting DESC script.

Rainer (2015) reminds us that providers from different cultures, including nurses, may have additional challenges employing effective communication and conflict engagement skills. While some difficulties are related to language barriers, others reflect differences in values associated with perceptions of patient autonomy, decision making, and workplace hierarchy. In a qualitative study exploring the ability to speak up and be heard, Garon (2012) reported that nurses who self-identified as Asian or Hispanic (n = 15) described endeavoring to emulate the assertive behavior of peer role models. The support of nurse managers in establishing an open, ethical environment that encouraged nurses to voice their concerns was also recognized as essential to speaking up by these participants.

Self-Care Competencies

Questions to Consider Before Reading On

1. What are your attitudes or feelings when you experience an ethical concern or conflict?

2. How would you describe your current level of moral courage?

Authors and researchers observe that moral distress in health care is not likely to go away and is “becoming part of our new normal” (Lavandero, as quoted in
Others note that experiences of moral distress can have a positive effect by increasing awareness of personal and institutional obstacles to ethical practice. This awareness can initiate a learning process that may contribute to a proactive approach as demonstrated by one nurse in a recent study who wrote, “I do more good by staying and correcting these distressing situations than I would if I left because they bothered me so!” (Sauerland et al., 2014, p. 242). A positive and proactive attitude may be enhanced by developing self-care competencies that address cognitive, somatic, and affective dimensions. These self-care competencies may also mitigate the physical and psychological symptoms associated with moral distress including headache, insomnia, and depression (Rushton, Kasniak, & Halifax et al., 2013; Sauerland et al., 2014, 2015).

**Box 4.4**

**Application of a Carefronting DESC Script**

Dr. C is a senior resident in the PICU and has had a good working relationship with the nurses. Recently, the unit has expanded to accommodate transplant patients and more nurses were hired. You are one of several newly hired nurses who feel intimidated by Dr. C as she is often rude and unhelpful. She is also slow to respond to pages and insists that only certain, “more experienced” nurses care for “her” patients.

Today, Dr. C has loudly complained about your assessment skills in front of others:

**Describe the behavior/situation:**

*Dr. C, this morning you shouted at me in the nurses’ station in front of others. This is not the first time you have spoken to me in that manner. (Stay silent)*

**Explain how the situation/behavior makes you feel and your concerns:**

*I feel angry and humiliated because it seems like you are trying to make me appear incompetent.*

**Suggest alternatives and seek agreement:**

*In the future, I would like you to talk to me personally if you have questions about my patient assessments as we are both here to provide safe patient care. Please do not raise your voice to me again. Are you committed to doing this? (Stay silent)*

**Consequences should be stated in terms of impact on goals/patient safety:**

*If you continue with this behavior, which I have documented, I will report it to (manager, supervisor, director) as it is bullying, against hospital policy, and affects my ability to provide safe care.*

*Sources: Kupperschmidt (1994, 2006, 2008).*

Wood, 2014). Others note that experiences of moral distress can have a positive effect by increasing awareness of personal and institutional obstacles to ethical practice. This awareness can initiate a learning process that may contribute to a proactive approach as demonstrated by one nurse in a recent study who wrote, “I do more good by staying and correcting these distressing situations than I would if I left because they bothered me so!” (Sauerland et al., 2014, p. 242). A positive and proactive attitude may be enhanced by developing self-care competencies that address cognitive, somatic, and affective dimensions. These self-care competencies may also mitigate the physical and psychological symptoms associated with moral distress including headache, insomnia, and depression (Rushton, Kasniak, & Halifax et al., 2013; Sauerland et al., 2014, 2015).
Although Provision 5 of the Code of Ethics states, “The nurse owes the same duties to self as to others including the responsibility to promote health and safety” (ANA, 2015a, p. 19), self-care education is rarely addressed in nursing or medical school curricula (Sanchez-Reilly et al., 2013). Indeed, as Blum (2014) observes, nurses express reluctance to take the time for self-care or have difficulty finding relevant activities that are easily adapted to their lives. A comprehensive review of the numerous self-care activities available is beyond the scope of this chapter. As Sanchez and colleagues note, however, self-care activities include a spectrum of knowledge, skills, and attitudes that contribute to personal resilience, defined as the ability to adapt coping strategies to minimize distress or the capacity to keep functioning in the face of stress, trauma, adversity, or tragedy (Rushton, Batcheller, Schroeder, & Donohue, 2015; Sullivan et al., 2012).

A fundamental, personal self-care strategy includes maintaining a healthy lifestyle by ensuring adequate nutrition, sleep, and exercise. In addition, time for vacations, family, and hobbies contributes to overall resilience. The Wellness Wheel, such as that used by the Vanderbilt University Wellness Center (2016), is an instrument that addresses eight dimensions of wellness (Figure 4.1). The Vanderbilt website link to each dimension of the wheel provides a definition and associated attributes in addition to suggested resources and articles. Consideration of each dimension may encourage reflection on current life balance and self-care activities. The American Nurses Association HealthyNurse initiative (2016b) offers a healthy nurse toolkit that provides information on nurse fatigue and preventing back injuries, among other issues. ANA has also collaborated with Pfizer to develop The HealthyNurse Health Risk Appraisal survey. This instrument provides real-time data on individual health, safety, and wellness, both personally and professionally. Upon completion of the survey, a nurse can compare his or her results to national averages and ideal standards and access resources individualized to his or her responses. The American Holistic Nurses Association (2015) also has extensive resources on stress management modalities including mindfulness meditation, journaling, and cognitive restructuring.

Lachman (as quoted in Jones, 2015) observes that moral courage (Chapter 2) is a means to overcome fear through practical action. Similarly, developing resilience to deal with ethical challenges may require a change in how nurses think about their roles and responsibilities, for example:

- Accepting change as a part of living
- Keeping things in perspective
- Avoiding seeing crises as insurmountable problems
- Looking for opportunities for self-discovery
- Maintaining a hopeful outlook
- Getting needed social support (Jones, 2015, p. 16)
Use of the tools and resources included in this section may enhance self-care competencies, increase resilience, and reduce the incidence of overall stress and moral distress.

**Organizational Competencies**

**Supportive, Ethical Leadership**

**Question to Consider Before Reading On**

1. How do your leaders provide you support in ethical situations in your work place?

Lack of supportive, ethical leadership is identified as contributing to a deficient ethical climate and subsequent moral distress among health care providers (Galletta et al., 2013; Makaroff et al., 2014). In contrast, the presence of ethical leaders who serve as mentors and role models for nurses enhances the moral community and may mitigate the causes and effects of moral dis-
tress (Edmonson, 2015). Chapter 8 discusses the components and behaviors of the ethical leader in more detail and recognizes that he or she can serve in an informal or formal leadership capacity. For example, the majority of members of the NEC at University Health System in San Antonio, Texas, are staff nurses. These informal nurse leaders provide ethics resources to their peers and may assist them in identifying, articulating, and addressing ethical conflicts and instances of moral distress (Sauerland et al., 2015).

As indicated in the Code of Ethics (Box 4.3), formal nurse leaders and administrators have a particular obligation to recognize and respond to issues that erode the ethical environment and contribute to moral distress among nurses. These leaders can preserve the moral integrity of nurses by developing and implementing policies and protocols that address identified concerns such as provider incompetence or incivility, unsafe staffing, and disruptive patient/family behavior, among others. They can also ensure that nurses are aware of and have access to ethics resources, continuing ethics education, and consultation services. In addition, they can support and respect those nurses who choose to exercise conscientious objection and serve as a representative voice in forums with other providers and health care administrators (Rushton & Kurtz, 2015).

To assist nurse leaders in being proactive about moral distress in clinical practice, Pavlish et al. (2016) developed the SUPPORT model. This model “provides strategies for nurse leaders to simultaneously develop nurses’ ethical skills and team based dialogue while also creating policies shaped by standards of healthy work environments and the American Nurses Association Code of Ethics” (p. 319).

Organizational Policies and Support Services

Organizational policies and programs that address specific causes of health provider moral distress such as disruptive patient/family behavior, provider incivility/bullying, and workplace violence are becoming more prevalent. Nurses should be familiar with and use those available at their facilities. If they are not available, nurses can work with other leaders to develop these resources and policies using examples provided in this chapter and in Box 4.5. One resource is The Safe at Hopkins (2015) program at Johns Hopkins University in Baltimore, Maryland. As with many institutions, Johns Hopkins has adopted a policy that calls for “zero tolerance of violent behavior, threats, bullying, intimidation, and any behavior of concern that contributes to an abusive environment” (2014, p. 2). The Safe at Hopkins program website provides online tools and resources to recognize and act upon behaviors of concern including a training module (2015). Another example with extensive resources and information is the stopbullyingtoolkit (2015) created by members of the Robert Wood Johnson Foundation Executive Nurse Fellows program.

Moral distress can occur when patient safety and patient/family satisfaction are given priority over the nurse’s safety and moral integrity (Lipscomb & London, 2015). Noting that the “nursing profession will no longer tolerate violence of any kind from any source” (p. 1), the ANA (2015b) has issued a
### Box 4.5

**Moral Distress Resources**

**Position Statements/Documents**


**Websites, Webinars, Videos, Toolkits**

- **Agency for Healthcare Research and Quality.** (2015). Successful outcome using TeamSTEPPS techniques. Retrieved from https://m.youtube.com/watch?v=yWd56QVL1VQ; https://m.youtube.com/watch?v=VX1kHduTHng; https://m.youtube.com/watch?v=ny1kr93_sKk

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*(continued)*
position statement on incivility, bullying, and workplace violence. This statement contains recommendations and resources for individual nurses and employers related to preventing and mitigating these damaging behaviors. An example resource is the NIOSH (2014) free online course entitled Workplace Violence Prevention for Nurses. The Emergency Nurses Association has also developed a Workplace Violence Toolkit (2010) to assist leaders at various levels in an institution to create a customized violence prevention plan. McPhaul, London, and Lipscomb (2013) have also created a research- and regulatory-based framework for establishing a comprehensive workplace violence prevention program.

In the Case Scenario presented in this chapter, the ADN student Jackie demonstrated uncivil behavior toward Marcia, the MSN student who attempted to speak with her about her inaccurate charting by stating, “You have no authority over me; you’re just a student too!” Clark, Barbosa-Leiker, Gill, and Nguyen (2015) observe that bullying and general incivility, whether instigated or experienced by students or faculty, is also a serious issue in nursing education. Clark has conducted extensive research on incivility in academic and work environments. She has developed a number of assessment tools, interventions,
and programs that can be adapted by students, practicing nurses, and formal leaders. For example, Clark’s civility curriculum includes signing a civility pledge, establishing classroom and clinical behavioral norms, and participating in communication and conflict negotiation simulations among other strategies (as quoted in Nikitas, 2014). The Clark Workplace Civility Index (CVI, 2013) is a tool for self-reflection that allows an individual nurse or other health care team member to assess his or her own civility level (Figure 4.2).

To complete the index, consider the 20 statements listed below. Read each statement carefully. Using a scale of 1–5; (5) always, (4) usually, (3) sometimes, (2) rarely, (1) never, select the response that most accurately represents the frequency of each behavior by asking yourself . . .

How often do I . . .

<table>
<thead>
<tr>
<th></th>
<th>Always (5)</th>
<th>Usually (4)</th>
<th>Sometimes (3)</th>
<th>Rarely (2)</th>
<th>Never (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assume goodwill and think the best of others</td>
<td></td>
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<tr>
<td>2. Include and welcome new and current colleagues</td>
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<td>3. Communicate respectfully (by e-mail, telephone, face-to-face) and really listen</td>
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<td>4. Avoid gossip and spreading rumors</td>
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<td>5. Keep confidences and respect others’ privacy</td>
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<tr>
<td>6. Encourage, support, and mentor others</td>
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<td>7. Avoid abusing my position or authority</td>
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<tr>
<td>8. Use respectful language (no racial, ethnic, sexual, age, or religiously biased terms)</td>
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<tr>
<td>9. Attend meetings, arrive on time, participate, volunteer, and do my share</td>
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<td></td>
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**Figure 4.2** Clark workplace civility index.

*Source:* Clark (2013). Used with permission. (The Clark Workplace Civility Index used herein is the copyrighted property of Dr. Cynthia Clark. The material should not be reproduced in any form without Dr. Clark’s expressed written permission.)
<table>
<thead>
<tr>
<th>Number</th>
<th>Task Description</th>
<th>Always (5)</th>
<th>Usually (4)</th>
<th>Sometimes (3)</th>
<th>Rarely (2)</th>
<th>Never (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Avoid distracting others (misusing media, side conversations) during meetings</td>
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<tr>
<td>11.</td>
<td>Avoid taking credit for someone else’s ideas/work/contributions</td>
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<tr>
<td>12.</td>
<td>Acknowledge others and praise their ideas/work/contributions</td>
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<tr>
<td>13.</td>
<td>Take personal responsibility and accountability for my actions</td>
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<td>14.</td>
<td>Speak directly to the person with whom I have an issue</td>
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<tr>
<td>15.</td>
<td>Share pertinent or important information with others</td>
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<tr>
<td>16.</td>
<td>Uphold the vision, mission, and values of my organization</td>
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<tr>
<td>17.</td>
<td>Seek and encourage constructive feedback from others</td>
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<td>18.</td>
<td>Demonstrate approachability, flexibility, and openness to other points of view</td>
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<tr>
<td>19.</td>
<td>Bring my ‘A’ Game and a strong work ethic to my workplace</td>
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<tr>
<td>20.</td>
<td>Apologize and mean it when the situation calls for it</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Subtotal</strong></td>
<td></td>
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</tbody>
</table>

Add the scores for each column; Enter your TOTAL score in the column to the right

Scoring the Clark Workplace Civility Index

- **90–100:** Very civil
- **60–69:** Barely civil
- **80–89:** Moderately civil
- **50–59:** Uncivil
- **70–79:** Mildly civil
- **Less than 50:** Very uncivil

*Figure 4.2 (continued)*
The CVI is designed to raise individual awareness and recognize civility strengths and areas for improvement (Clark, 2013).

To create and sustain civility at the organizational level, Clark (2013) has developed an eight-step framework, the Pathway for Fostering Organizational Civility (PFOC, Figure 4.3). As can be seen, this is a cyclical process designed to engage nursing and other leaders at various levels in the organization with the goal of promoting “collegiality, teamwork, and collaboration—and ultimately a culture of civility” (p. 182). As Clark observes, this process is based on the premise that simply raising awareness is insufficient; rather a sustained and dedicated commitment coupled with adequate resources is needed for transformational change. In addition, pre- and postorganizational evaluations are required. These assessments are done to identify areas needing improvement and those with clear policies and procedures for addressing incivility and rewarding civil, collegial behaviors (as cited in Nikitas, 2014).

**Figure 4.3** Pathway for fostering organizational civility.

Questions to Consider Before Reading On

1. Do you feel there is a need for improvement in your workplace civility?
2. How do you think that could be accomplished?

This chapter has emphasized the need to have organizational support services such as ethics consultation, education, and employee assistance programs for those experiencing moral distress. Chaplaincy departments and ethics consultation services may also provide individual assistance or unit-based debriefings when moral distress is affecting health care team members. Epstein and Hamric (2009) observe, however, that traditional ethics consultation for moral dilemmas or conflicts may overlook the presence of moral
Recognizing and Addressing Moral Distress in Nursing Practice

distress, which may be the underlying reason for calling the consult. They instituted a Moral Distress Consult Service (MDCS) at the University of Virginia Health System that seeks to address the three levels of moral distress concerns or causes: the patient/family, the unit/team, and the organization. The consultants endeavor to find a time where all members of the team can meet, talk about the issue, and try to identify the “right” thing to do and barriers preventing them from doing so. The team then works together to identify and prioritize strategies to get around the barriers that may be at one or more of the three levels. Dr. Epstein states that team members have to realize that they are not weak or unusual in their experiences of moral distress and what they see as the right action might have several different avenues. She observes that “the key is addressing it [moral distress] somehow,” whether it be through a formal consult or unit-based discussions (E. Epstein, personal communication, July 9, 2015). Jeanie Sauerland, the assistant director of nursing ethics at University Health System in San Antonio, Texas, and an ethics consultant, provides an example of a unit-based discussion/consultation for moral distress in Box 4.6.

**Box 4.6**

**Moral Distress—Unit-Based Discussion/Consultation**

**BACKGROUND**

The consult was initiated by a staff nurse and the unit nurse manager in response to a patient/family situation resulting in moral distress among the health care team members. The patient, Mr. S, had been hospitalized for many weeks, was experiencing organ failure, and was in great pain. On several occasions, he had requested that interventions be stopped and providers were willing to honor his wishes. The patient’s wife, however, objected to withdrawing care and instituting a do not resuscitate (DNR) order. Mrs. S would speak with her husband, resulting in his autonomous decision to continue aggressive care. Nurses who cared for Mr. S believed that they were contributing to his pain and suffering by continuing to provide nontherapeutic interventions. In addition, the providers were angry with Mrs. S whom they saw as prolonging the dying process.

**DISCUSSION/CONSULTATION**

Ms. Sauerland and the nurse manager arranged meeting times for both shifts that could be attended by as many providers (nurses, physicians, respiratory therapists, chaplain) as possible. After listening to the views of the participants, Ms. Sauerland discussed the difference between a moral dilemma and moral distress (Box 4.1). She observed that moral distress is a highly personal experience rooted in personal and profes-
sional values, and, for nurses, relieving pain and suffering is a primary professional value. The primary value for Mr. S, however, is perhaps not to disappoint or abandon his wife by “giving up”—as this may be more emotionally and physically painful for him than enduring continued interventions. Ms. Sauerland suggested to the providers that they step back and acknowledge both their pain and that of the patient and his wife. She reminded them that family dynamics are deeply entrenched and few of us know how we would respond if a similar situation involved someone we love. Ms. Sauerland stated, “When we’ve hit that ‘it was just wrong’ button, we need to talk about the situation. What felt right, what felt wrong, and what we would do differently the next time. We have to support each other.” Sharing, understanding, and respecting each other’s stories, those of the patient, his wife, and the providers, may not result in a solution or prevent moral distress but allows us to imagine the best possible way to act in the situation (Frank, 2014).

CONCLUSION
The night shift nurse caring for Mr. S encouraged Mrs. S to participate in care activities, as she (the nurse) believed it might enable her to see and experience his continual pain and suffering (Adams, Bailey, Anderson, & Docherty, 2011). This strategy resulted in a turning point, a reframing of hope, and a revision of their stories, as Mrs. S was able to let go and aggressive care was stopped.

Ms. Sauerland followed up with the unit nurse manager and made several recommendations that addressed aspects of the three levels of moral distress: the patient/family, the unit/team, and the organization (Epstein & Hamric, 2009; Hamric, 2014):

- Encourage early family meetings between days 3 and 5 of the patient stay to begin discussions about the goals of care and provide frequent, consistent communication with patients/family members.
- Provide education to the interprofessional team regarding how to recognize and speak up about moral distress.
- Empower all team members to initiate ethics consults and/or seek assistance to work through situations of moral distress.
- Encourage communication and collaboration with palliative care services.
- Strengthen the unit ethical climate.
- Identify root causes of moral distress and develop strategies to address them.
CHAPTER 4  Recognizing and Addressing Moral Distress in Nursing Practice

Building organizational competencies to address moral distress contributes to development of an ethical climate and a moral community. An individual nurse may feel that this organizational challenge is beyond his or her level of duty or influence. The NEC and unit-based ethics steward program discussed in this chapter and Chapter 2, however, demonstrates that this transformation can begin with one or more motivated individuals. In discussing organizational civility, Clark (2013) likens this process to that of a single seedling in an aspen grove; however, this metaphor can also be applied to developing a moral community:

[T]he workplace is a constant flow of interaction and relationships between and among individuals. We continuously affect one another as well as being affected by the organizations in which we work. Organizations are living systems and, fostering change is an organic process that ultimately proliferates and thrives. Like an aspen grove, the process for fostering organizational civility might begin with one seedling of change that grows and spreads by sending runners that take deep root to fortify and reinforce the strength of the system. (pp. 180–181)

CONCLUSION

This chapter identified and discussed four responses to ethical situations, including that of moral distress. The origin of the concept of moral distress was presented followed by a description of personal, professional, and organizational causes. Current interventions and strategies to address moral distress at the personal, professional, and organizational levels were explored. Table 4.2 provides a summary of moral distress causes and interventions/strategies to address them.

<table>
<thead>
<tr>
<th>CAUSES OF MORAL DISTRESS</th>
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</thead>
<tbody>
<tr>
<td><strong>Personal and Professional Factors</strong></td>
</tr>
<tr>
<td>Protecting position or reputation</td>
</tr>
<tr>
<td>Lack of ethical knowledge/sensitivity</td>
</tr>
<tr>
<td>Perceived powerlessness</td>
</tr>
<tr>
<td>Past experiences</td>
</tr>
<tr>
<td>Emotional stability</td>
</tr>
</tbody>
</table>

(continued)
Critical Thinking Questions and Activities

1. What did you learn from the chapter Case Scenario?

2. Think of an ethical conflict you have experienced. Use the CUS (I am Concerned, I am Uncomfortable, this is a patient Safety issue) and DESC (Describe, Express, Suggest, Consensus) to replay your communication in these situations. What did you learn?

3. What would you do differently in your workplace based on the principles and content presented in this chapter?

4. Use Figure 4.1 to assess your current self-care and identify ways to improve your self-care.

5. Use Figure 4.2 to reflect on your personal level of workplace civility.

6. Give suggestions as to how your workplace could increase its organizational civility using the pathway in Figure 4.3.

7. Explore the additional resources provided in Box 4.5. Choose one from each section and discuss its relevance to your practice with a class peer or colleague.

Table 4.2

<table>
<thead>
<tr>
<th>Causes of Moral Distress and Interventions/Strategies (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Factors</strong></td>
</tr>
<tr>
<td>Deficient ethical climate</td>
</tr>
<tr>
<td>Fear of reprisal for actions</td>
</tr>
<tr>
<td>Lack of ethical leadership</td>
</tr>
<tr>
<td>Limited ethics resources</td>
</tr>
<tr>
<td>Inadequate/incompetent staff</td>
</tr>
<tr>
<td>Bullying, lateral violence, incivility, workplace violence</td>
</tr>
</tbody>
</table>

**MORAL DISTRESS INTERVENTIONS/STRATEGIES**

**Personal and Professional Competencies**

- Ethics education—formal courses and continuing education
- Effective communication and conflict engagement skills
- Self-care competencies

**Organizational Competencies**

- Supportive, ethical leadership
- Organizational policies
- Support services
REFERENCES


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PART II  ■ Skills and Resources for Ethical Decision Making

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CHAPTER 4  ■ Recognizing and Addressing Moral Distress in Nursing Practice


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Exploring Ethical Issues Related to Emerging Technology in Health Care

CAROL JORGENSEN HUSTON

LEARNING OBJECTIVES AND OUTCOMES

Upon the completion of this chapter, the reader will be able to:

- Discuss how the ethical principles of dignity and autonomy are challenged by technology
- Identify strategies to optimally integrate the use of technology with the human element or art of nursing
- Analyze difficulties in weighing the costs and benefits of technology use in health care
- Explain the challenges to ensuring ongoing, technological competence in nursing
- Identify the nurse’s role in contributing to the ethical use of technology

As an RN you most likely have been able to see how technology is dramatically changing the world around us and this is especially evident in health care settings. Electronic health care records, smart devices, robotics, clinical decision support, and genetics are just a few of the technologies changing the health care landscape. In fact, one could argue that nothing has changed or will change the way nursing is practiced more than advances in technology. Indeed, the current rate of technology development and implementation is staggering. Andersen and Rasmussen (2015) suggest that society is transformed whenever new technologies emerge that change our means of production and ability to communicate and that the rapid technological development of the past century—in biotechnology, information technology, nanotechnology, and artificial intelligence—holds promise to do the same for our current,
postindustrial world. As all of this occurs, it is good to reflect upon the statement made by Elvin Charles Stakman (1949): “Science cannot stop while ethics catches up. . . . And nobody should expect scientists to do all the thinking for the country.”

**CASE SCENARIO**

As the “nurse” in the family, relatives often call to solicit health care advice. Julie, your sister-in-law, called this morning and shared that her 40-year-old sister was recently diagnosed with ovarian cancer. Because of a fairly strong family history of ovarian and breast cancers in her family, she is considering genetic testing (BRCA) to better assess her own risk, but is concerned about the confidentiality of these data.

When she discussed it with her husband, he discouraged her, suggesting that she was overreacting, that they could not afford it, and that having the genetic marker could increase the cost of life insurance or have other negative financial repercussions down the road. Julie feels she could keep the costs lower and control the confidentiality of results better if she did her testing privately through a low-cost commercial vendor online but knows that the results may have less reliability/validity and be less comprehensive than if it was ordered by her physician (subtyping could be included). She also mentions, however, that insurance might cover the cost of the testing if it was ordered by her physician, but the results then would be a part of her permanent medical record.

In addition, when she mentioned the possibility of genetic testing to her two daughters, one daughter said, “Do it if you must, but I do not want to know the results as it could influence my decision to marry and have children.” The other daughter encouraged her to have the testing, suggesting that she would want to know the results right away so that she could do whatever necessary to mitigate her own risk.

Ethical issues contained in the case: confidentiality, autonomy, paternalism, beneficence, truth telling, duty-based ethics, nonmaleficence, justice

It is disconcerting that in many cases, technology mania has occurred without the much needed, prior critical analysis of the ethical questions surrounding its development and use. Certainly the old adage “If we build it, they will come” is at least somewhat true when discussing technology advances in health care. One must at least question whether some new technologies should be built at all, who should come, and what the unintended consequences might be once these technologies are created.

Pickersgill (2013) agrees, suggesting that as new health technologies are introduced, transformations in the meanings of care occur. For example, as patients gain new choices in care options as a result of emerging technologies, new questions arise as to how to mandate and monitor “good care.” Thus, care becomes more mutable and context-specific; furthermore, risk increases
that “good” care may entail practices of coercion. Gabr (n.d.) concurs, suggesting that vigilance systems are needed to ensure that rapid advances in science and technology will not result in uncontrollable evolution or unacceptable deviation or harm.

Questions to Consider Before Reading On

Returning to the Case Scenario, Julie asks you to help her think through what decision she could make and asks you what other issues she should consider.

1. Can Julie make a decision that is truly unencumbered by the wishes of others?
2. Can Julie actually “control” confidentiality in this case?
3. Can Julie protect her “right to know her genetic data” and also protect her daughter’s “right not to know”?

This chapter addresses some of the ethical considerations associated with emerging technologies in health care including how the basic ethical principles of dignity and autonomy are challenged by technology; the need to balance technology and the human element; the difficulty in weighing the costs and benefits of technology in health care; the challenges inherent in ensuring ongoing technological competence in the workforce; and the ongoing struggle by to ensure that technology use is ethical (Table 11.1). In addition, the chapter suggests strategies nurses might use to lessen the potential ethical dissonance between increasingly technologically driven practice and ethical practice.

DIGNITY AND AUTONOMY

A problem noted by Daniel Dennett (“Ethical Quotes,” 2001–2015) was “that no ethical system has ever achieved consensus. Ethical systems are completely unlike mathematics or science. This is a source of concern.” Multiple ethical

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principles are relevant when looking at the potential impacts of emerging technology: justice, autonomy, fidelity, paternalism, fairness, beneficence, confidentiality, dignity, autonomy, and agency, to name just a few. Given space constraints, however, only two are discussed in this chapter: dignity and autonomy.

**Question to Consider Before Reading On**

1. Do new discoveries related to human enhancement pose ethical threats to human dignity or are they supported by beneficence?

**Dignity**

Merriam-Webster defines *dignity* simply as “the quality or state of being worthy, honored, or esteemed” (“Dignity,” 2016). The International Federation of Social Workers (2012), however, suggests a greater complexity to the definition of dignity, noting that dignity entails respecting the right to self-determination, promoting the right to participation, treating each person as a whole, and identifying and developing strengths in others.

The right to self-determination is discussed with autonomy in this chapter. It is the subdefinition of “treating each person as a whole” that may be most threatened by emerging health care technologies since technology-enhanced diagnosis and treatment are frequently directed at specific body parts rather than a more holistic approach.

For example, Chan (2015) suggests that dignity may be threatened by technology advances such as genetics since genetic research tends to reduce individuals to their genetic endowment. Wadhwa (2014) agrees, noting that, while access to and use of genetic information may promote better diagnosis and treatment, such information can also be used to restrict an individual’s freedoms and right to participation by care as a sole result of his or her genetic structure. For example, Wadhwa notes that the Genetic Information Nondiscrimination Act of 2008 prohibits the use of genetic information in health insurance and employment, but provides no protection from discrimination in long-term care, disability, and life insurance. And, it places few limits on commercial use. There are no laws to stop companies from using aggregated genomic data in the same way that lending companies and employers use social-media data, or to prevent marketers from targeting ads at people with genetic defects.

Similarly, the John J. Reilly Center (2015a) suggests that new discoveries related to human enhancements pose ethical dilemmas to dignity since magnifying some aspect of human biological function beyond the social norms violates the treatment of the individual as a whole. It also results in physical risk and creates an unlevel playing field (some individuals are artificially enhanced). For example, drugs designed to treat attention deficit hyperactivity disorder can also be used to enhance the alertness and cognition of those...
Without the disorder. While using performance-enhancing drugs such as stimulants, blood-boosters, and synthetic growth hormone is generally considered unethical by bodies that govern academics and athletics since they violate expectations of fairness and equity, the John J. Reilly Center (2015a) questions whether such enhancements are really unethical if they can be justified on utilitarian grounds. They also promote self-determination and promote strengths in individuals (part of the definition of dignity).

Allhoff, Lin, Moor, and Weckert (2009) suggest, however, that human enhancement technologies directly impact “human dignity” (p. 7); what it means to be human. For instance, they question whether the desire for enhancement shows ingratitude for what we have and (further) enables an attitude of unquenchable dissatisfaction with one’s life. Would human enhancement technologies hinder moral development since many believe that “soul-making” is impossible without struggle? Is the frailty of the human condition necessary to best appreciate life? Can or should children be enhanced to give them an edge in society? Allhoff and colleagues (2009) conclude that a sensible middle path may be the best choice at this point in time and encourage individuals to use their own moral compass to find answers to these difficult questions.

Questions to Consider Before Reading On

1. In reflecting on the Case Scenario, should Julie’s desire to protect her daughter’s “right not to know” change if she actually develops genetically susceptible cancer?

2. Should Julie’s decision to be tested be influenced by her daughter’s wish to not know the results?

3. Does the duty to warn outweigh the need to promote autonomy?

Autonomy

Merriam-Webster defines “autonomy” as “the quality or state of being self-governing” or having “self-directing freedom and especially moral independence” (“Autonomy,” 2016). Rhodes (2013) agrees, suggesting that the ethical principle of autonomy represents a demanding standard for the self-regulation of one’s actions since it gives beings moral worth and holds people responsible for their actions. With autonomy, individuals are viewed as having a distinctive self-legislating ability (assumes decisional capacity) and this requires others to respect their choices.

In health care, however, patients do not always have the capacity or the desire to make autonomous health care decisions. Indeed, the health care system historically has been paternalistic and the ethical principle of agency has been used to justify decision making based on what the provider considered the most appropriate course of action. Merriam-Webster defines agency as “the capacity, condition, or state of acting or of exerting power” to achieve
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an end (“Agency,” 2016). Agency, however, should also be viewed as a moral directive as most individuals have notions of right and wrong and are held accountable to take actions that are beneficent.

The Internet is one example of an emerging technology that has significant potential to impact patient autonomy. Historically, providers were recognized as the keepers of medical information. This allowed them to be the primary health care decision maker, often relegating patients to a somewhat passive and dependent role (Huston, 2013). The Internet changed these dynamics because it expanded the power and control of health information from providers alone to patients themselves. Indeed, the Internet, which is growing faster than any other medium in the world, has great potential to improve health by enhancing communications and improving access to information for care providers, patients, health plan administrators, public health officials, biomedical researchers, and other health professionals.

Indeed, thousands of health information websites currently exist for consumers to explore in attempting to answer their health-related questions and more are launched daily. “Indeed, when it comes to health-related mobile technology, patients may be more frequent users than health care professionals. Thousands of software applications are developed each year just for personal health issues and medical conditions, and they are easily accessible from smartphones and tablets.”

The end result is that patients have electronic access to medical information on virtually any topic, any time. This suggests that many consumers have at least the opportunity to be better informed about their health care problems and needs than in the past. In fact, this increased opportunity for consumers to access information has resulted in the creation of what is known as the expert patient—a patient who has the confidence, skills, information, and knowledge to participate in his or her health care.

Theoretically, expert patients are better informed and thus better able to be active participants in decision making. Although most providers appreciate well-informed patients who have demonstrated the initiative to learn more about their health care needs and problems, there are concerns regarding the accuracy and currency of information patients find on the Internet. In addition, many patients do not fully understand the information that is available to them, even when it is accurate. Some providers are concerned that patients will inappropriately self-diagnose, leading them to seek inappropriate treatment or no treatment at all.

In addition, little research has been done to validate the currency or accuracy of the information on health care Internet sites. Krotoski (2011), citing a recent study or more than 12,000 people across 12 different countries, noted that more people than ever are using the web to find out more about an ailment before or instead of visiting the doctor. Alarmingly, only a quarter of the people surveyed checked the reliability of health information they found online by looking at the credibility of the source. In addition, Krotoski suggests that “a typical medical consultation follows this trajectory:
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1) you discover a growth, 2) do a Google search, 3) believe the first result that confirms your expectations” (para 6).

Krotoski concludes then, that while the wealth of health information online has contributed to a more informed public, the expertise of the professional should not be undermined by the leveling power of the web. Clearly, patients need to become experts at retrieving health care information and deciphering it to better empower themselves in health care decision making and to promote autonomy.

Question to Consider Before Reading On

1. What safeguards exist or could be created to better ensure accuracy and currency of layman health care information posted on the Internet?

BALANCING THE HUMAN ELEMENT AND TECHNOLOGY

Munro (2012) states:

For each of us there is a moment of discovery. In the flash of a synapse we learn that life is elemental. This knowledge changes everything. We see all things connected. The element not listed on the chart—is the missing element—the human element. And when we add it to the equation—the chemistry changes. Every reaction is different. The human element is the element of change. Nothing is more fundamental. Nothing more elemental.

The human element is the art of nursing and nurses need to be actively involved in determining how best to use technology to supplement, not eliminate, human resources (Huston, 2013). One of the most significant challenges nurse leaders face in using technology is to find that balance between maximizing the benefits of using that technology, while not devaluing the human element. Nurses need to make sure that the human element is not lost in the race to expand technology. Pols (2015) agrees, suggesting that nurses, patients, and ethicists have expressed concern that “care through technology can become a cold and dehumanizing affair.” This is certainly a potential concern with the use of robots as caregivers, with the Internet as a health care tool, and with some new technological devices.

Questions to Consider Before Reading On

1. What aspects of physical and mental nursing care do you believe could or should be replaced by robotics in the coming decade?

2. Are the elderly at greater risk of technology-related harm and ethics violations than other age groups?
Robots as Caregivers

Robotics provides a clear example of how the human element is being replaced by or supplemented with technology. Indeed, in some parts of the world, robots are being developed to provide direct patient care, particularly for the elderly. This is especially true in Japan, known as the “Robot Kingdom,” as a result of a burgeoning elderly population and a low birth rate, which has resulted in a severe shortage of caregivers (Huston, 2013).

For example, physical service robots have been created to help with tasks such as washing or carrying elderly people, and mental service robots provide emotional support through therapeutic listening and feedback (robots use vision systems to monitor human expressions, gestures; use body language and voice sensors to pick up on intonation and individual words and sentences; and sense human emotion through wearable sensors that monitor pulse rate and perspiration). In addition, robotic walkers now exist that can obtain information about the environment through sensors, cameras, obstacle recognition systems and software. These walkers can guide elderly users to paths that minimize the chances of stumbling and falls (European Commission, 2015).

Sharkey and Sharkey (2012) suggest, however, that the increased use of robots in elder care raises a number of ethical concerns, including the potential reduction in the amount of human contact (opportunities for human social contact can be reduced); an increase in the feelings of objectification and loss of control (robots lack sensitivity to people’s feelings and provide care at the convenience of caregivers); a loss of privacy; the loss of personal liberty; deception and infantilization (robots may restrict the behavior of humans); and a lack of clarity regarding the circumstances in which elderly people are allowed to control the robots (who is responsible if things go wrong?).

Sharkey and Sharkey suggest that at present:

Apart from fundamental human rights legislation, there is little protection for elderly people against the potential downsides of robot care. In particular, there are no obvious restrictions on the amount of time that elderly people could be left in the care of robots, nor on the amount of human contact that they should experience. Like children, the very old and infirmed can be seen as being in need of special protection. (p. 33)

Huston (2013) notes that many consumers and health care providers negate these ethical concerns arguing that the lack of emotion in patient care robots is the element of human caregivers that can never be replaced. However, as technology continues to advance, the ability to distinguish robot from human caregiver is declining. The appearance of robot caregivers is increasingly lifelike, and Sharkey and Sharkey (2012) note that this physical embodiment means that they can be used to perform tasks in the world to a
greater extent than purely computational devices. Their often personable appearance may lead them to be welcomed in the home and other locations, (where for instance a surveillance camera would not be accepted) and their personable, or animal-like, appearance can encourage and mislead people into thinking that robots are capable of more social understanding than is actually the case.

In addition, although machines have historically been unable to demonstrate caring, the development of new robotic devices is beginning to challenge this long-held belief. Researchers at the Georgia Institute of Technology have developed “Cody,” a robotic nurse the university says is “gentle enough to bathe elderly patients” (Bilton, 2013). “Hector,” a robot developed by the University of Reading in England, can remind patients to take their medicine, keep track of their eyeglasses, and assist in the event of a fall (Bilton, 2013).

Some robots are even being created with the purpose of therapeutic communication or interaction. Crisotomo (2015) and Bilton (2013) note that “Paro,” a therapeutic robot that looks like a baby harp seal, is meant to have a calming effect on patients with dementia and Alzheimer’s in health care facilities. First introduced last 2010, Paro was developed by Fujisoft to literally talk with its users and is currently used in nursing homes worldwide. More recently, Softbank’s “Pepper” robot was designed not only to chat, but also to alter its reactions and speech by sensing and “feeling” the emotion of its users (Crisotomo, 2015).

Similarly, a laboratory at Carnegie Mellon has designed a robot to work with therapists and people with autism (Bilton, 2013). The machine can develop a personality and blinks and giggles as people interact with it. Jim Osborn, a roboticist and executive director of the Robotics Institute’s Quality of Life Technology Center at the university, noted that those who tested it loved it and hugged it, and began to think of it as something more than a machine with a computer.

Indeed, Cynthia Breazeal, founder of the world’s first social robot for the home called “Jibo,” suggests that technology and humans can and should work hand in hand. She argues that what is being created are robots that are really teammates and that these robots should complement the services that human professionals can provide (Fox, 2015).

Sharkey and Sharkey (2012) agree in that they suggest that while all of us should be concerned about the use of robots for elder care, it is not the use of robots in elder care per se that should be of concern; it is the ways in which they are used. Sharkey and Sharkey suggest positive contributions by robotics including the following:

Assistive robots and robotic technology could help to overcome problems of mobility, and reduce elderly people’s dependence on busy, and sometimes inattentive, care staff. The use of remote controlled robots to monitor, and virtually visit elderly people could enable the elderly to live independently for longer. Robots could remind them...
what medicines to take, watch out for health problems and safety risks. Companion robots could facilitate the social lives of elderly people, by giving them an interesting gadget to talk to other people about. Social interaction could also be facilitated by monitoring robots that enabled virtual visits from friends and family. (p. 30)

Bilton (2013) expresses concern, however, in his warning that given the increasing number of elderly people and the decline in the number of people to take care of them, it is likely that robots will start to fill in the care gaps. Sherry Turkle, a professor of science, technology, and society at the Massachusetts Institute of Technology and author of the book *Alone Together: Why We Expect More From Technology and Less From Each Other*, voiced her concerns as well in sharing that she was troubled when she saw a 76-year-old woman share stories about her life with Paro, the robotic seal. Turkle suggests, “We have been reduced to spectators of a conversation that has no meaning,” and since robots do not have a true capacity to listen or understand something personal, tricking patients to think they can is unethical (Bilton, 2013). Debates, then, about how best to merge the human element of care (caring) and emerging robotic technology will undoubtedly continue.

The Internet

The Internet is another example of a technology that may significantly impact or interfere with the relationship between the caregiver and the patient, with Bajarin (2015) identifying the Internet as the most disruptive innovation of our time. For example, Dombo, Kay, and Weller (2014) suggest that maintaining professional boundaries becomes more challenging and critical for health care providers when online treatment or forms of communication are involved. The online setting may give the impression that the health care provider is always available, which can create unintentional opportunities for a client to feel rejected or for boundary violations on the part of the professional, particularly if she or he is immediately responsive on weekends and evenings through a variety of messaging mediums.

In addition, Harris and Robinson Kurpius (2014) report that mental health graduate students often engage in ethically questionable behavior as part of social networking, including such activities as conducting online searches for client information without informed consent. More than half of these students they studied did not believe their graduate programs adequately addressed professional social networking guidelines and slightly less than half did not believe their professional organization adequately addressed professional social networking guidelines. Students noted they needed additional guidance on how to navigate ethical dilemmas created by social networking.

Privacy concerns related to Internet use also pose ethical considerations. Walcerz (1999–2015) notes that many websites collect user data, from user-
names and passwords to personal information such as addresses and phone numbers, without the explicit permission of users. Selling this information is widely considered unethical, but is often in a legal gray area because the user provides the data in the first place. Similarly, copyright and intellectual property rights are continually threatened by the Internet as a publishing medium with the end result being a host of ethical concerns related to plagiarism and piracy.

Technological Devices

Da Silva and Ferreira (2013) note that two forms of nursing action exist in the field of intensive care: caring and technological action. “Caring requires a greater application of knowledge, which directs the attention of nurses in search of the client’s objective and subjective data, as well as data from the devices. The technological action is mostly sustained by information from the technological device, leading professionals to perform actions based on data supplied solely by the device” (p. 1324).

Da Silva and Ferriera (2013, p. 1324) suggest these two forms of nursing action lead to conflict with some suggesting that more attention to objectivity involved in care occurs with the technological actions and that this occurs at the expense of expressiveness or caring. Others, however, believe that “the fact that the nurse concentrate his observation more on certain critical situations that require technology for care does not presuppose a notion primarily of devaluation of subjectivity, indicating a mechanistic view, or lack of patient care, seen as inhumane conditions.”

Van Manen (2015) suggests that even routine, noninvasive technologies, however, may impact the patient–provider or patient–family relationship and that these technologies are often a taken-for-granted part of the medical lifeworld. For example, van Manen suggests that while providers may view the neonatal cardiorespiratory monitor as a relatively simple technology to assist with vital signs and patient monitoring, it also may be a barrier to parent–child interaction. Van Manen concludes that, as the monitor is woven into human relationships, the monitor may carry more ethical significance than other seemingly ordinary things since the monitor penetrates the ethical moment, the ethicality of ethics, as it weaves into the relation of self and other, parent and child.

Dombo et al. (2014) also suggest that technology may promote a lack of face-to-face interactions between the patient and the provider. Practitioners may struggle with communication dynamics that inhibit building rapport and engagement when they are unable to read nonverbal cues when using e-mail or messaging. Additionally, there appears to be a distinct lack of regulation of what care should and should not be provided virtually.

Pols (2015), in detailing several case studies involving teledcare, agrees, noting that “noisy technology” must be turned off since people and devices direct
each other and each tries to “act back” at the other in order to establish a workable, livable, or even a good situation. In her case studies, telepatients . . .

did not check their figures on the television, but trusted their nurses to call them if something was wrong. Webcams seduced people to contact each other about disease in daily life, but people used them to discuss many other things as well. Hard working nurses and frail elderly are notoriously difficult to organize “around the table.” Attending to what they do, and how this expresses their practical knowledge and normative solutions is a way of making them heard. Not as autonomous spokespersons, but as the relational beings an empirical ethics wants to articulate. (p. 90)

Another ethical consideration associated with the use of medical devices includes whether adequate safeguards are in place for the patients who use them. For example, the John C. Reilly Center (2012) notes that implanted medical devices, such as pacemakers, are susceptible to hackers who can breach the security of the wireless device from a laptop and reprogram it to deliver an 830-volt shock. How do we make sure these devices are secure?

Similarly, Dodds (2015) notes that unlike the case of developing a new drug, stem cell therapy (e.g., that used in 3D printing) cannot be tested on a sizable number of healthy people prior to being tested on patients and then, finally, being made available as a standard treatment. The point of using a patient’s own stem cells is to tailor the treatment quite specifically to that patient, and not to develop a treatment that can be tested on anybody else. She concludes that researchers must continue to develop new models for testing technological discoveries and treatments for safety and effectiveness before their implementation to overcome this ethical concern.

**BALANCING COSTS AND BENEFITS**

**Questions to Consider Before Reading On**

1. In reflecting on the Case Scenario, does potential socioeconomic discrimination discourage individuals from testing for genetically susceptible cancers?

2. What safeguards could be put in place to reduce this risk?

The United States is home to numerous technology developments that have led to health care advances and improved quality of life. Huston (2013) notes, however, that the U.S. health care system is already the most expensive health care system in the world and technology is one of the leading cost drivers. Sivy (2012) agrees, suggesting that while new technology sometimes reduces health care costs, mostly it drives spending higher.
In addition, since access to technology is often dependent on a person’s ability to pay for that technology, many health care disparities still exist in this regard. Dodds (2015) asks, “Should these treatments only be available to those who can pay the additional cost? If so, then those patients who lack financial resources may not receive effective treatments that others can access for a range of serious conditions.”

The reality is that emerging diagnostic and treatment technologies are expensive and thus may need to be used selectively. Decisions about who should have access to them and at what cost are at the heart of many ethical debates.

The Markkula Center for Applied Ethics (n.d.) suggests that the same technologies that offer hope for ever-increasing life expectancy (e.g., promising cancer treatments, surgical procedure and pharmacological breakthroughs, and advanced genetic research) are also leading to increased demands on the health care system from a growing population of senior citizens. “Ethicists and health professionals alike are now raising questions about when and from whom treatments should be withheld, as competition for the scarce medical resources of the health care system grows beyond the system’s capacity to provide care for everyone. Already, some forms of rationing have been implemented, and more rationing of health care resources may be inevitable” (Markkula Center, n.d., para 2). Should health care technology be rationed by age? By ability to pay? By perceived potential contributions to society at large?

Sivy (2012, para 4) agrees, suggesting that as health care spending soars, thorny ethical questions will become more urgent. When should aggressive treatment be limited for someone who is terminally ill? More than 30% of the Medicare budget is now spent on patients in their last year of life, and the benefits of that treatment vary enormously. Who decides how much to do?

Similarly, Dodds (2015) notes that while the introduction of 3D printing has offered great benefits in medicine, it also raises a number of ethical questions as the technology develops. For example, she notes that if the technology can be used to develop replacement organs and bones, could it not also be used to develop human capacities beyond what is normal for human beings? Should existing bones be replaced with artificial ones that are stronger and more flexible, less likely to break; or muscle tissue be improved so that it is more resilient and less likely to become fatigued, or new lungs be implanted that oxygenate blood more efficiently, even in a more polluted environment?

Dodds (2015) goes on to caution that 3D printing could be associated with military use with the idea that it could provide an advantage if our soldiers were less susceptible to being wounded, fatigued, or harmed in battle. She notes that “while it is clear that it would be preferable for military personnel to be less vulnerable to physical harm, the history of military technology suggests that 3D printing could lead to a new kind of arms race. Increasing the defenses that soldiers have in the face of battle would then lead to increasing the destructive power of weapons to overcome those defenses. And in so doing, increasing the harm to which civilians are exposed.”
In addition, questions have been raised about whether need drives technology or whether technology is driving need. For example, a 2011 study showed that after Wisconsin hospitals acquired robotic surgery technology, the number of prostate removals they performed doubled within 3 months. In contrast, the number of prostate surgeries stayed the same at hospitals that did not purchase the new $2 million technology ("Do Robots Drive Up Prostate Surgeries?," 2011). One must question whether surgeons at hospitals with robots are recommending surgery for men with prostate cancer because the outcomes (potential reductions in incontinence and impotence) are better or whether the new technology is simply more exciting than alternative treatments like radiation or "watchful waiting" ("Do Robots Drive Up Prostate Surgeries?" 2011).

Furthermore, Hansen and Gee (2014) suggest that “scientific inertia” exists regarding new technology due to the scientific requirement for high levels of proof via well-replicated studies; the need to publish quickly; the use of existing intellectual and technological resources; and the conservative approach of many reviewers and research funders. Indeed, since 1996, the funding of environmental, health, and safety (EHS) research represented just 0.6% of the overall funding of research and technological development (RTD).

Compared with RTD funding, EHS research funding for information and communication technologies, nanotechnology, and biotechnology was 0.09%, 2.3%, and 4% of total research, respectively. The low EHS research ratio seems to be an unintended consequence of disparate funding decisions; technological optimism; a priori assertions of safety; collective hubris; and myopia. Clearly then, more EHS research is needed to anticipate and minimize potential hazards while maximizing the commercial longevity of emerging technologies (Hansen & Gee, 2014). Without such research, accurately balancing cost and benefits is almost impossible.

This is especially the case when emerging technologies may provide the only hope for patients. Sivy (2012) notes that newspapers feature on a regular basis, stories about patients being denied access to new high-tech treatments. Often, these treatments are outrageously expensive with only a small chance of extending life for a relatively short period. A public outcry ensues, debates continue about whether the treatment should be funded, and patients often die in the meantime. Whatever the outcome is, no one is ever really satisfied.

Sivy (2012, para 10) goes on to suggest that when it comes to controlling technology, directing medical research is a monumental task. “Some discovery that affects only an obscure disease might be the key to unlocking something much more important. And having made such a discovery, is it ethical to refuse to make it available to someone whose life might be saved, even if the odds are low? Similarly, should a hospital not buy and use some exotic scanning machine if that might be the only way to diagnose certain rare diseases? Should progress be limited simply because it might lead to higher costs?”
Sivy (2012, para 1) concludes then that:

While policy experts complain that America has been slow to address its long-term economic problems—and unrealistic when such issues are actually discussed, there has been even greater evasion and denial when it comes to the ethical dilemmas that will accompany those economic problems, especially where healthcare is concerned. Politicians talk as though relatively painless solutions can be found. But in reality there is no magical escape from difficult choices—they can only be dealt with by facing up to them squarely.

ENSURING TECHNOLOGY COMPETENCE IN THE WORKFORCE

It has been said, “Technology is dominated by two types of people: those who understand what they do not manage, and those who manage what they do not understand” (“Technology,” 1977–2001).

Technology is not only expensive (both initially and in terms of maintenance and technical support), but also needs constant upgrades, and the education needed to truly be competent in the use of all this technology is never ending. This is certainly the case in newer “smart” technologies such as infusion pumps, beds, bedside medication verification systems, drug dispensing machines, and other clinical tools in use today.

Perhaps though, one of the best current examples of where technology introduction has preceded workforce competence is the use of genetic testing. The John J. Reilly Center (2015b) notes that within the last 10 years, the creation of fast, low-cost genetic sequencing has given the public direct access to genome sequencing and analysis, with little or no guidance from physicians or genetic counselors on how to process the information.

Calzone and colleagues (2010) agree that despite a burgeoning body of evidence regarding the contribution of genetics and genomics to health or illness, there is little evidence of a genomically competent nursing workforce. They suggest that “in order for people to benefit from widespread genetic/genomic discoveries, nurses must be competent to obtain comprehensive family histories, identify family members at risk for developing a genomic influenced condition and for genomic influenced drug reactions, help people make informed decisions about and understand the results of their genetic/genomic tests and therapies, and refer at-risk people to appropriate health care professionals and agencies for specialized care.”

Indeed, Calzone and colleagues (2010) argue that bringing all 2.9 million nurses in the U.S. workforce to the forefront of genetics/genomic health care practice is appropriate, as nurses must elicit health-related information, recognize what is important, and subsequently act upon that information in caring for the patients they serve. Calzone and colleagues suggest that public...
policies that affect health care practice in the area of genetics/genomics will be stronger with inclusion of nurses and professional nursing organization representation in the policy-making process.

Similarly, Kamei (2013) suggests that telenursing requires advanced abilities and specialized knowledge since telenurses must have a deep understanding of the latest knowledge in the areas in which they conduct telenursing as well as highly developed critical thinking skills, the provision of information based on evidence, excellent patient teaching, counseling, and communication skills, and expertise in the use of telecommunication devices.

Huston (2013), however, asks:

Who is going to train all the healthcare professionals who will work with new emerging technologies? More importantly, who will need to be responsible for assuring ongoing competency in a digital era where half of what someone knows is obsolete in three years?

There are no national standards for defining, measuring, or requiring continuing competence in nursing. In addition, specialty nursing organizations, state nurses associations, state boards of nursing, and professional nursing organizations have not reached consensus about what continuing competence is and how to measure it, although there is little debate that it is needed. Huston (2014a) suggests the reality is that given the multiplicity and variations of the definition of continuing competence and the number of stakeholders affected by its promulgation, identifying and mandating strategies that ensure the continuing competence of health care providers will be very difficult.

The responsibility, then, for initial as well as continued competence then in the use of emerging technologies really falls to the license holder. Ward (2012) iterates that patients trust that their nurses are competent in their practice. This means that nurses must be compliant with Board of Nursing standards and they must complete necessary continuing education or whatever is necessary to demonstrate their competency.

Questions to Consider Before Reading On

1. How much input do nurses have at your place of practice in terms of the selection and use of new technology? Are ethical considerations included in these acquisition decisions?

2. What can or should a nurse do when his or her personal values appear in conflict with the organizational values regarding the ethical use of technology?

ENSURING THAT TECHNOLOGY USE IS ETHICAL: NURSING’S ROLE

Wood (2013) suggests that when nurses encounter ethical dilemmas in situations in which they cannot do what they consider to be “the right thing,” they
experience moral distress. Indeed, the problems faced by health care leaders regarding technology will increasingly be what is called *wicked*—meaning that they have many causes, they are tough to describe, and there is no right answer.

To counter this moral distress in technology-related ethical dilemmas, Huston (2013) suggests that nurses must increasingly speak up and ask “how” and “why” technology should be implemented. What parameters need to be put into place to determine its ethical use? These questions and others related to the ethical use of technology should be reviewed by ethics committees prior to the technology implementation and nurses should have a voice in that discussion.

In addition, Mayhew (n.d.) suggests that agencies should provide all employees with ethics training that engages them in scenarios to learn how to address and resolve ethical dilemmas. Policies should be developed that hold employees accountable for their actions and alert them to their responsibilities in upholding professional standards. In addition, Mayhew suggests that an ombudsperson should be available to assist employees with workplace ethical concerns and that an ethics hotline be available to employees who encounter ethical dilemmas that put them or patients into uncomfortable or threatening positions.

In a recent speech, Thomas Baldwin, a professor of philosophy at Britain’s York University, suggested that new technologies bring significant hopes of curing terrible diseases as well as fears about the consequences of trying to enhance human capability beyond what is normally possible (Kelland, 2012). Baldwin concluded that the blurring of the line between man and machine will continue to pose concerns about the ethics of emerging technologies in medicine and other fields. It is important for nurses to be a part of conversations to address these ethical concerns.

**CONCLUSION**

Huston (2014b) notes that evolving technologies offer great opportunities to improve the quality of patient care, but technology alone is not the answer. Regardless of the system that is deployed, health care organizations must consider what technology can best be used in each individual setting and how it should be used ethically. In addition, successfully adopting and integrating new technology requires care providers to understand that technology’s limitations as well as its benefits.

Unfortunately, Wadhwa (2014) suggests that with the pace of technology growth, we have not been able to come to grips with what is ethical, let alone determine what laws or rules should be in place. Gabr (n.d.) agrees, suggesting that the ethical consequences associated with technological change must be further examined and that some institutionalization of health ethics should be required. In doing so, new, sensitive, reliable indicators as well as
Critical Thinking Questions and Activities

1. In the chapter Case Scenario, can Julie’s health care providers make appropriate health care assessments/treatment plans if they are not given access to Julie’s genetic screening results?

2. What makes new technology worth the cost? What criteria should be used in making these value-based decisions?

3. Should health care technology be rationed by age? By ability to pay? By perceived potential contributions to society at large?

4. What emerging technologies are being introduced where you practice (as a student or as a nurse) that you believe need further ethical analysis/safeguards for patient use prior to their implementation?

5. Florence Nightingale said, “Rather, ten times, die in the surf, heralding the way to a new world, than stand idly on the shore” (“Florence Nightingale,” 2015). How can you apply this quote to the use of technology in your current nursing practice?

6. What does the following quote mean to you in terms of your nursing practice?

   *Ours is a world of nuclear giants and ethical infants. If we continue to develop our technology without wisdom or prudence, our servant may prove to be our executioner.*

   Omar Bradley (“Quotations by author,” 1977–2001)

7. What strategies could the professional nurse use to deemphasize the cold dehumanizing aspects of technological device use and reinforce the human caring (art of nursing)?

8. Consider the following information and questions from the John J. Reilly Center at the University of Notre Dame:

   Genetic testing has resulted in huge public health successes (diseases can now be prevented or helped by early intervention), but it also creates a new set of moral, legal, ethical, and policy issues surrounding the use of these tests. If the testing is useful, how do we provide equal access? What are the potential privacy issues and how do we protect this very personal and private information? Which genetic abnormalities warrant some kind of intervention? How do we ensure that the

   (continued)
information provided by genome analysis is correct (especially in the case of at-home tests)? Are we headed toward a new era of therapeutic intervention to increase quality of life, or a new era of eugenics? (John J. Reilly Center, 2015b, para 2).

Critical Thinking Questions and Activities (continued)

REFERENCES


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**ADDITIONAL BIBLIOGRAPHY**


