Notes and summary of themes from February 2, 2017 – Nursing Ethics at the Heart of Health Care Discussion Group

During this discussion group we talked about the reasons that people had decided to join and shared some ethically distressing experiences that we had encountered. Our group was comprised entirely of nurses, working in different capacities in health care. Floor, ICU and Emergency Room nurses, educators, managers, instructors, students were all present.

• Medical Model versus Nursing Model
  o Medical model is focused on how to fix things, and is constructed based on specialties.
  o Nursing model is more holistic,
  o A surgery that “takes care of” many areas at once might be considered successful and effective for the doctor, but a nurse sees that the patient is now unable to take care of themselves and maintain autonomy due to their limitations during recovery.

• Philosophies of Care & History of Medicine and Nursing
  o We didn’t discuss this much, but I feel that it’s an essential element to building a foundation in ethical thinking. Stephen shared a philosophy that I didn’t write down, but I would encourage you to all revisit a philosopher that “clicks” with you. The work they’ve done can help guide you through your thought process for the next ethically challenging situation you encounter.

• What is ethics?
  o Essentially, it is not meant to find answers… it is asking the right questions. To me, this means that although we may have institutional constraints that limit our options, asking the right questions will help find the best process for dealing with a situation.

• Moral Distress
  o Related to the above – it is the experience of not being able to “do the right thing” due to organizational constraints. This might be a policy or the authority of another person. The effect is that a person feels unable to act according to their values. Nurses are very susceptible to this due to the organizational position of their work, and healthy coping skills must be developed and maintained in order to prevent burnout. It’s important to recognize that many of our peers engage in “unhealthy coping skills”, which isn’t a fault of their own, and they shouldn’t be judged for it. What we can do is offer a better way to support each-other so that we can be empowered to act and think in an ethical way.

• Shared Stories
  o We shared a few powerful stories about the ethical situations that we’ve encountered in patient and family care. As nurses, we are often looked to by friends and family to “know what’s best”, which is something I hadn’t thought to address during this discussion group. I’m so glad that it came up. We listened to each other’s stories and offered our reflections about them in an effort to better understand what happened, why, and what the
options are during this situation. We noted that it’s important to remember that we are trying to examine these situations from an “ethical lens”, but there are many other perspectives, such as legal, clinical, psychological, etc.

- **Denise’s story** – Reflection on a patient with dementia and the difficulty surrounding resolving a small bowel obstruction
  - We discussed the role or lack-of-role of family advocates, patient autonomy, “reasonable” care, and focused in on that the outcome and interventions seemed reasonable, but the process seemed unnecessarily distressing.

- **Lynn’s story** – reflection on a patient whose prognosis was very poor, but doctors “practiced” on anyway. This is a case that caused so much distress that Lynn felt she had to cope by removing herself from practice in that unit – which is sometimes the only thing you can do to cope. The problem was that the outcome/purpose/reasons for the interventions given did not align with an ethical practice.

- We discussed how some units support each other – such as the PICU. When there is an “unexpected event” there is a debriefing lead by the anesthesia attending. The event does not necessarily have to have a bad outcome for this to happen, and the process is healing.

- Palliative care takes a moment before their meeting to recognize the people they have lost that week, which Peter finds support in due to the overwhelmingly sad situations his job requires that he engage in.

- Much discussion about end-of-life care and palliative care
  - Medicine is “how to live” – palliative care is “how to die” – and everyone is on this spectrum.
  - The average length of stay in hospice is only 6 days, palliative care is often consulted very late
  - “Dying is un-American”
  - When is it not appropriate for a patient to make decisions for themselves?
  - How do you make decisions for your family & patient?
    - Sarah’s example of her grandfather and the relationship of the intervention being offered and “how far off baseline” it is?
    - I’ll send this article
  - “The Conversation Project” – Ellen Goodman
    - [http://theconversationproject.org/about/ellen-goodman/](http://theconversationproject.org/about/ellen-goodman/)
    - [https://www.youtube.com/watch?v=xbWcLYOniWU](https://www.youtube.com/watch?v=xbWcLYOniWU)

- **Litigation in Medicine**
  - Very high in OB/GYN - what is the impact on care? What is the impact on the decisions that doctors make
  - The change in paternalism to patient-driven-care

- **Risk Management versus Ethics Consult**
  - Risk Management puts the hospital first, Ethics puts the patient first.