Nursing Ethics at the Heart of Healthcare
Summary of April 6, 2017
Conflict in Values in Multidisciplinary Care

Historical overview of Physician - Nurse dynamic
Supreme Court case in 1949, McConnell vs. Williams was the source of the idea of a surgeon as “captain of the ship”
- Discussion group concluded that while ICU intensivists or surgeons may continue to feel a sense of responsibility for what happens in these isolated care areas, the model of “captain of the ship” is no longer present. Medicine is moving toward specialization, with each member of a multidisciplinary team responsible for their own contribution to care.
- Different levels of training and expertise may result in more or less professional responsibility and therefore liability, but this does not inform each person’s level of ethical responsibility. Instead, the discussion group concluded that each person should be equally ethically accountable.

Review of Suzanne Gordon’s 7-steps
Suzanne Gordon argues that in order for nurses to avoid slipping back into a subservient role we need to participate as assertive team members. She recommends 7 steps to improving relations with physicians.
- Group felt that BMC nursing already functioned as assertive team members, and that BMC physicians valued nursing input and insight. For example, physicians seeking out nurses to participate in rounds.

Different perspectives result in different decisions and different struggles
Shared results of the study: Doctors and nurses perceptions of ethical problems in end-of-life decisions.
- Nurses’ and physician’s framework for understanding ethics is based on different models and therefore is likely to affect their values and perspectives. Bioethics (the basis for medical ethics) includes the application of autonomy, beneficence, nonmaleficence and justice. Nursing ethics are rooted in the patient-nurse relationship.
- Doctors tended to focus on quality of life, inappropriate hospitalization, and cost of care, while nurses focused on patient/family preferences, pain management, implementing treatments, and discharge planning.
- Doctors suffered more moral dissonance: stress or discomfort from holding contradictory ideas or values, while nurses suffered more moral distress: stress or discomfort from knowing the right thing to do, but being unable to do it because of constraints
- Uncertain patient prognosis can make decision making difficult and make it harder to know what the “right thing to do” is. “Doctors bore the burden of having to make the decisions and write the orders, whereas nurses’ burden entailed living with the decisions made by someone else.” This group identified with the challenges of having to care for patients that are receiving aggressive end-of-life treatment, while holding different personal values. While blunt end-of-life conversations are difficult, it is our duty to advocate for and facilitate these necessary conversations.
Decision making when patients or families are not comprehending the facts

Families are often asked to serve as proxies and help make decisions on behalf of the patient. Due to a variety of factors, the reality of the situation does not always sink in. Stress, emotions, medical literacy can all make it impossible to truly inform the family.

- It was asked whether it was ethical to “put a spin” on the facts in order to help guide decision making that (from the provider’s standpoint) would benefit the patient or do we have an obligation to remain 100% objective? The group concluded that often families want help making decisions.
- Discussed the idea that physicians are “experts of medicine”, while the family is an “expert on the patient”. The best-case scenario involved giving the family a professional recommendation, while empowering them to think about their family member’s individual values.

Conflict between professional duty and personal responsibilities: Ebola

Currently the WHO reports the EVD case fatality rate to be 50%. The first case of EVD in the US occurred on September 30, 2014; Thomas Eric Duncan was diagnosed while visiting Dallas Texas.

- Parallels between the AIDS epidemic were made.
- Nurses have a unique duty, a duty to provide care regardless of the characteristics of the patient. However the ethical theory of consequentialism informs us that the greater good must be considered. Risking infection of others to save one life is not ethical.
- In times of disaster allocation of goods needs to be considered, this includes staffing for the other patients with good prognoses.
- In situations where there are adequate volunteers, hospitals should not mandate participation in the care of EVD infected patients.

Navigating differences between personal values and patient values

In healthcare we often care for patients with different personal values. When patients express beliefs that a nurse or other patients are uncomfortable with (i.e. racist remarks), how can we move forward with care and maintain a therapeutic relationship?

- The group concluded that it is not a nurses’ role to influence a patient’s non-health related beliefs. Making accommodations to protect other patients is not endorsing the offensive statements, but instead looking out for the greater good of the unit.
- Staff should feel empowered to address offensive statements in a professional way
- To protect the quality of care that the patient receives, as well as to protect the staff, nurses unable to provide unbiased care should be reassigned.

The stigma of being labeled “difficult”

Patients can be labeled as “difficult” if they are belligerent, use abusive behavior, foul or inappropriate behavior, have poor personal hygiene, are confused or non-compliant. While it can be helpful to discuss psychosocial elements to a patients care, are we setting them up for impartial care when we pass this along to the next nurse?

- The group concluded that discussing psychosocial elements of patient care could be helpful to the next nurse and benefit the patient. For example, passing along that a pediatric patient with autism with doesn’t like to be touched is useful.
- Information passed along between caregivers that is based on our own personal frustration or dislike of a patient, can ultimately penalize the patient over the course of their hospitalization. Staff may enter the room with expectations, resulting in them being more defensive, less patient, etc.
- Flexibility and patience can be a critical tool for success with patients that are trying to refuse nursing care.