DOWNLOAD PDF THE MORAL REASONING OF NURSES WHO WORK IN THE ADULT INTENSIVE CARE SETTING

Chapter 1 : Project MUSE - Nursing Ethics: A Selected Bibliography, to Present

Values, Moral Reasoning, and Ethics ï»¿ Omery, Anna () The Relationship Between Moral Reasoning, the Relationship Dimension of the Social Climate of the Work Environment, and Perception of Realistic Moral Behavior Among Registered Professional Nurses ï»¿.

Abstract The challenging nature of neonatal medicine today is intensified by modern advances in intensive care and treatment of sicker neonates. These developments have caused numerous ethical issues and conflicts in ethical decision-making. The present study surveyed the challenges and dilemmas from the viewpoint of the neonatal intensive care personnel in the teaching hospitals of Tehran University of Medical Sciences TUMS in the capital of Iran. The physicians and nurses of the study hospitals were requested to complete a item questionnaire after initial accommodations. Content validity and internal consistency calculations were used to examine the psychometric properties of the questionnaire. There were significant differences between sexes in the domains of the perceived challenges. According to the linear regression model, the perceived score would be reduced 0. It can be concluded, therefore, that more attention should be paid to these issues in educational programs and ethics committees of hospitals. Due to the nature of their career, health team members are constantly exposed to ethical issues and challenges such as abortion, end of life care, and medical errors 1 , 2. There are fundamental differences between adults and children, and therefore the issues related to children and infant care and ethical decision-making are quite different. Although neonatal wards are always filled by moral conflicts, amazing advances in the care of critically ill neonates have led to challenging established standards and clear procedures in neonatal care 3 , 4. These advances have caused more conflicts in ethical decision-making and developed more ethical challenges. In a study on 70 physicians and caregivers, ethical problems were reported, which means an average of three problems per person. In other words, each caregiver was confronted by more than one ethical problem on a regular basis 5. It is clear that a single person or group of people cannot make the right decisions without proper training, and therefore hospital ethics committees and ethics consultation were created 3 , 6. The latter has been introduced as a mechanism approved by ethics experts to help in situations of moral conflict 6 , 7. Similarly, important decisions are made by ethics committees based on the long established practices in developed countries 8. However, ethics committees and ethics consultation have only been introduced to the Iranian health system in recent years. Although some studies have been conducted to identify the most common ethical issues of the medical system in Iran 9 , less attention has been paid to issues in the field of neonatology. This survey evaluated these matters from the viewpoint of the neonatal intensive care personnel in the teaching hospitals of Tehran University of Medical Sciences TUMS in the capital of Iran. Materials and methods This was a comparative cross-sectional study conducted between March and February The study population consisted of physicians including neonatologists, fellows of neonatology, and residents of pediatrics and nurses of the neonatal care units level II and III of the teaching hospitals affiliated with TUMS. The samples were collected from the neonatal units of seven teaching hospitals using convenience sampling method. The first phase of the study was to design a valid and reliable tool for assessing the ethical issues in neonatal units. First, related sources of data, including theses, dissertations and electronic databases PubMed, Science Direct and Proquest were examined for a suitable questionnaire. The used keywords were ethical, issues, dilemmas, challenges, neonatology, and NICU. The research team designed a new questionnaire for the purpose of this study. Common ethical issues and challenges were extracted through interviews with experts in the field of ethics and neonatology, and literature review, and the results were gathered together as a questionnaire. After six revisions of the questionnaire by the research team and consultations with ethics experts, the first draft was designed with 60 items. An expert panel consisting of two neonatal care professors, two medical ethics experts and three members of the research team revised the questionnaire further and omitted, modified or merged some questions. The final instrument included 36 questions related to ethical issues and consultation. In the pilot

phase, a sample of 20 nurses and physicians completed the questionnaire and the final adjustment was performed accordingly. In the main phase of the study a three-part questionnaire was prepared as reported above. The first part contained demographic questions, including variables such as age, gender, and work experience. The main part consisted of the first 36 questions of the developed questionnaire, designed to assess the ethical issues and challenges in neonatal care. Ethical issues were divided into four domains: The questions are presented in table 1.

Chapter 2 : Online RN-BSN Curriculum | Online BSN Courses

The Moral Reasoning of Nurses Who Work in the Adult Intensive Care Setting ï»¿ Omery, Anna Kathryn () Culpability and Pain Management/Control in Peripheral Vascular Disease Using the Ethics of Principles and Care ï»¿.

This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. However, Gilligan noted that care and justice perspectives coexist in moral conflict, and during the growth process, each complements each other and promotes moral development and maturation. In this paper, we analyzed publications that used Gilligan protocol to conduct research on moral conflicts experienced by nurses. Our analysis suggests that attachment and connections based on relationships with patients and self-care are essential elements of care, and self-care is important in moral decision making. The inequality between nurse and physician roles was an issue raised with the justice perspective. With moral development, humans began to express the care and responsibility they acquired as what Gilligan calls the ethics of care and responsibility. Gilligan [1] also noted that the counterpoint of identity and intimacy that marks the time between childhood and adulthood is articulated through two different moralities whose complementarity is the discovery of maturity. That is, care and justice perspectives coexist in conflict, and during the growth process, each complements each other and promotes moral development and maturation. Kuhse [2] stated that a partialist ethics of care can never account for the whole of ethics, an adequate ethics needs impartiality as well as care. Ethics can be considered from the care and justice perspectives, and through these perspectives, proper judgments can be made. Care has numerous definitions, but can be broadly divided into behavior, posture and attitude. In the nursing field, the act of nursing itself is often referred to as care. In care ethics, however, the nuance of posture and attitude is stronger. Gilligan [1] stated that a progressively more adequate understanding of the psychology of human relationships informs the development of an ethic of care, and Noddings [3] noted that the essential elements of caring are located in the relation between the onecaring and the cared for. Nursing finds its basis in the relationship between a patient and a nurse who provides assistance. The essence of nursing is care, and care ethics serves as an important perspective. Without the justice perspective, nurses may be influenced by subjective judgments. Thus, the ethics of justice also plays an important role in nursing. Both care and justice perspectives help nurses in ethical decision making. The aim of this study was to analyze previous studies that used GP in order to establish a foundation for incorporating the care and justice perspectives in analytical studies of moral reasoning in nurses. Inclusion criteria were publications which assessed moral conflicts experienced by nurses and used a categorization table for care and justice perspectives based on GP. Content analysis was performed on the details of care and justice perspectives extracted from these publications. We also summarized the views of the authors of each publication using direct quotes. Target Publications Based on a PubMed search, we identified six publications that used GP, 5 of which targeted nurses, and 3 of which used a categorization table for care and justice perspectives Table 1. All publications surveyed the decision making of nurses in situations involving moral conflict. A summary of the nursing research using the protocol of Gilligan. Chally [10,11] included some additional questions which addressed conflicts and solutions, as well as those related to the evaluation of choices made. The first reading was performed to understand the conflict as a whole, the second reading focused on the thought process and behavior of the person who had the conflict, and the third and fourth readings were from the viewpoints of care and justice, respectively. Chally [10,11], also included a fifth reading in order to address perspectives other than those of care and justice. Furthermore, Chally, as well as others [9], and categorized the moral decision making of nurses based on whether the care or justice perspective dominated. Most nurses used the care perspective, followed by those who used a combined care and justice perspective, and lastly the justice perspective Table 2. The specific details of care and justice perspectives are provided in Table 3. Chally [10] identified the following as care concepts from moral conflicts experienced by NICU nurses: According to

Chally [10], all the nurses expressed an understanding of the care perspective. Nurses discussed care orientation from the perspective of not hurting. Care took the form of protecting the neonates from pain and hurt. Nurses expressed concern about the pain endured by their patients. First, the data suggested that the nurses were attuned to specific needs of the neonates, both physically and psychologically. Examples of this category of the care perspective reveal the nursing expertise of those interviewed: The nurse expressed concern about the quality of life that might be experienced by neonates who were discharged from the unit [10]. The term attachment describes a relationship between two or more people based on love and acceptance. Attachment and connection emerged as important components of the care perspective. Nurses expressed attachment and connection to neonates, parents, and colleagues [10]. Care of self was the final category identified by the nurses. The nurse described how they were able to continue working in the NICU despite the heavy emotional toll. They described a process of detaching or separating from their patients. This served a protective function. Another way the nurses cited they cared for the self was by taking pride in the quality of nursing care given. The nurses described being comforted by the knowledge that they did their best [10]. Similar to the care categories discussed above, Chally [10] identified the following justice categories: Contents of care and justice obtained from the study. The justice perspective was found to be used far less often that the care perspective when NICU nurses made moral decisions. For these nurses, correct behavior seemed to be determined by fixed rules and the maintenance of social order through the legal system [10]. Nurses described the justice orientation from the perspective of rights. For them, rights were similar to laws. Nurses discussed the justice orientation from the rules perspective. At times, the nurses indicated that they coped with moral dilemmas by following orders or protocols and by not thinking about the situation [10]. They suggested that physicians were obligated to cure. Another aspect of the justice category was that the unit serving as the research setting was located in a teaching hospital where residents needed to learn certain procedures and techniques. A commitment to educate health-care providers was a problem in some situations [10]. Nurses also discussed the justice orientation from the perspective of societal concerns. Five nurses voiced concerns about US society in general. A common theme throughout the interviews was the inequality of roles between nurses and physicians. The nurses were distressed by role constraints they identified as results of this inequality [10]. The care taxonomy described by Chally remained valid for the care perspective described by adult intensive care nurses. The various methods of describing care, identified as care taxonomy, were all described by the adult intensive care nurses as they discussed dilemmas experienced in professional practice. All nurses, both neonatal and adult intensive care, used the attachment and connection category as they described moral dilemmas [11]. The significance of self-care was documented in this research as the category remains an important component of the care taxonomy [11]. If nurses learned the importance of caring for self, they may find themselves less stressed and less likely to burnout, either physically or emotionally [11]. A major component of the justice taxonomy as discussed by nurses interviewed was roles. Nurses frequently discussed moral dilemmas related to the inequality of roles between nurses and physicians [11]. Millette [9] categorized interview results based on the degree of predominance of the care and justice orientations, and presented and analyzed the details of representative cases. In the pure care orientation narrative, the caring perspective was the only perspective that was evident [9]. In the mostly caring orientation narrative, the nurse related the characteristics of her relationship with the elderly patient, and admiration and affection toward the patient were emphasized. In the mostly justice orientation narrative, the nurse frequently referred to principles and rights. At the military hospital ward where she worked, the nurse found out that an enlisted patient did not have his body temperature taken, but rather a false temperature was recorded. The problem was successfully resolved when the enlisted patient conferred with the previous chief nurse of the ward. The nurse suggested that patient care was compromised due to the parties involved prioritizing their military careers. Chally [10] indicated that difficult moral decisions are being made every day in the field, and stressed the importance of understanding the decision making perspective of nurses. As suggested by Chally b , nurses are concerned with both justice and caring. To understand moral decision making, all perspectives

must be explored as possible frameworks for the deliberation of moral dilemmas [10]. Opinion of about the utility of the Gilligan theory in the analysis of the moral conflict of the nurse. Categories other than care of self were included in the second stage goodness as self-sacrifice , and care of self was included in the third stage morality of non-violence. Roles was included in Stage 3 interpersonal morality , legal issues, rights, rules, and obligations and commitments were included in Stage 4 morality of social systems , and societal concerns was included in Stage 5 morality of social contracts. These tools were developed under the assumption that all people strive to deliberate dilemmas from the justice perspective. Because this study offers evidence that not all nurses deliberate moral dilemmas from the justice perspective, the continued use of tools developed solely on the justice perspective seems questionable [10]. The care perspective is described as one of connection, interrelatedness, and attachment among people. Choices are made because of understanding the uniqueness of the situation and connections between people. Principles are not necessarily applied impartially to situations because the uniqueness of each circumstance precludes such detachment [11]. Chally [11] further suggested that exposure to more than one perspective of moral decision making may result in identification of alternatives to moral issues that would have not been obvious with use of only one perspective. Moreover, Millette [9] noted Gilligan does not say that either perspective is better but that they are different approaches to solving dilemmas, she contended that caring is an exclusively feminine perspective. Based on this, Millette [9] stated that the care orientation does, however clarify and explicate some of the situations that women, and especially nurses, have experienced in their lives. This approach directs the researcher to ask the subject to describes a moral situation in which there is a moral choice, and then to define and explore the personally experienced moral situation [9]. Characteristics of Care and Justice in Moral Conflicts Experienced by Nurses Our analysis confirmed that care is a perspective held by all nurses. While the first stage relates to self-centered judgments, the second stage involves empathy for others, and the third stage involves care of self while considering relationships with others. Nursing comes into effect based on the relationship between the one caring and the one cared for. Consistent with this, Noddings [3] noted that to care is to be in a burdened mental state, one of anxiety, fear or solicitude about something or someone. Moreover, regarding the provision of care, Noddings [3] stated that I care for someone if I feel a stir of desire or inclination toward him, I care for someone if I have regard for his views and interests, I have the care of an elderly relative if I am charged with the responsibility for his physical welfare. In other words, through the relationship with one cared for emerges emotions for and an understanding toward that individual, translating into caring behavior.

Chapter 3 : Values, Moral Reasoning, and Ethics

In a health clinic, the nurse is conducting medication education for a patient with hypertension, who is an older Asian adult. During the education session, the patient does not speak to the nurse, but nods in agreement.

Nurses encounter these dilemmas in situations where their ability to do the right thing is frequently hindered by conflicting values and beliefs of other healthcare providers. In these circumstances, upholding their commitment to patients requires significant moral courage. Nurses who possess moral courage and advocate in the best interest of the patient may at times find themselves experiencing adverse outcomes. These issues underscore the need for all nurses in all roles across all settings to commit to working toward creating work environments that support moral courage. In this manuscript the authors describe moral courage in nursing ; and explore personal characteristics that promote moral courage , including moral reasoning, the ethic of care, and nursing competence. Morally responsible nursing consists of being able to recognize and respond to unethical practices or failure to provide quality patient care. Ethical dilemmas in practice arise when one feels drawn both to do and not to do the same thing. They can cause clinicians to experience significant moral distress in dealing with patients, families, other members of the interdisciplinary team, and organizational leaders. Nurses experience moral distress, for example, when financial constraints or inadequate staffing compromise their ability to provide quality patient care. Nurses who consistently practice with moral courage base their decisions to act upon the ethical principle of beneficence doing good for others along with internal motivation predicated on virtues, values, and standards that they believe uphold what is right, regardless of personal risk. Ethical values and practices are the foundation upon which moral actions in professional practice are based. The foundation of quality nursing care includes nurse practice acts, specialty practice guidelines, and professional codes of ethics. Familiarity with these documents is necessary to enable nurses to question practices or actions they do not believe are right. Although a code of ethics and ethical principles can guide actions, in themselves they are not sufficient for providing morally courageous care. Moral ideals are needed to transcend individual obligations and rights. The moral commitment that nurses make to patients and to their coworkers includes upholding virtues such as sympathy, compassion, faithfulness, truth telling, and love. Nurses who act with moral courage do so because their commitment to the patient outweighs concerns they may have regarding risks to themselves. In this manuscript the authors begin by describing the concept of moral courage. Next they explore personal characteristics that promote moral courage, including moral reasoning, an ethic of care, and nursing competence. Organizational structures that support moral courage, specifically organizational mission, vision, and values; models of care; structural empowerment; shared governance; communication; a just culture; and leadership are addressed. Moral Courage in Nursing Nurses who act with moral courage do so because their commitment to the patient outweighs concerns they may have regarding risks to themselves. Packard and Ferrara proposed that nursing is comprised of four components. Nurses who are morally courageous are able to confidently overcome their personal fears and respond to what a given situation requires; they act in the best interests of their patients Day, Nurses who exhibit moral reasoning and act with moral courage demonstrate a willingness to speak out and do that which is right in the face of forces that would lead a person to act in some other way Lachman, They noted that nurses practice with moral courage when they confront situations that pose a direct threat to care. This nursing response is based upon a commitment to serve and advocate for patients and the profession. Kidder has argued that an individual who acts with moral courage is committed to moral principles, cognizant of the actual or potential risk that upholding those principles may require, and willing to endure the risk. Purtilo identified moral courage as a necessary virtue for healthcare professionals, one that enables them to not only survive but to thrive in changing times. Purtilo noted that morally courageous individuals respond to situations that incite fear and anxiety without knowing the end result of their response because they believe in doing what is morally right. The nurse on a general medical unit, for example, who confronts the physician who is reluctant

to transfer an acutely ill patient in need of intensive care to the ICU, is acting with moral courage so as to provide safe care for the patient. Personal Characteristics that Promote Moral Courage in Nursing Nurses can enhance their ability to demonstrate moral courage in nursing by advancing their moral reasoning skills, nurturing their personal ethic of care, and enhancing their professional and cultural competence. Each of these behaviors will be discussed below. They understand their role responsibilities and how an ethical environment supports their identification of ethical issues and concerns. They engage in meaningful ethical discussions Murray, The Ethic of Care in Nursing The ethic of care is characterized by attentiveness, responsibility, competence, and responsiveness. Rather, it is a way of practicing that requires specific moral qualities that facilitate taking the right action Tronto, The ethic of care is characterized by attentiveness, responsibility, competence, and responsiveness. Nursing practice that includes the ethic of care promotes moral courage. Moral courage is enhanced in situations in which the ethic of care is present as evidenced by building consensus, promoting interdisciplinary collaboration, and positively influencing outcomes that support rather than oppose moral decision making LaSala, Consider, for example, a nurse caring for a patient with invasive ductal breast carcinoma and spinal metastases who desires to die at home surrounded by family and assisted by a hospice team, but whose husband is hesitant about taking his wife home, fearful that he will be unable to manage her care. Nursing Competence Professional competence is a prerequisite for providing morally responsible care. Standards for ethical conduct are also necessary in order to provide morally responsible care Maraldo, Leininger defined transcultural nursing as a humanistic and scientific area of formal study and practice focused upon similarities and differences among cultures with respect to human care, health, and illness that are related to cultural values, beliefs, and practices norms. These norms include the way rights and protections are exercised, and even what is considered to be a health problem United States [U. Nurses need to understand and appreciate inherent similarities and differences not only locally, but regionally, nationally, and worldwide as well. These same institutions showed remarkable resilience in limiting turnover and maintaining patient and staff satisfaction. Structures that are described below help create the context for actualizing moral courage in nursing. Mission, Vision, and Values Creating the foundation for an environment that fosters moral courage among nurses requires that all stakeholders have a clear understanding of the organizational mission, vision, and values, as well the philosophy of the nursing department Lachman, Clearly stating and supporting the mission, vision, and values sets the tone for the work of nursing in the organization, pictures a state that implies a commitment to organizational improvement, and suggests the types of activities that will ensure that the organization reaches those goals. Developing a nursing philosophy allows the organization to define itself not only to its internal community, but to its external community as well. Models of Care Professional practice models include reward and recognition systems acknowledging performance improvement The American Nurses Credentialing Center AACN has defined a professional practice model as the driving force of nursing care; a schematic description of a theory, phenomenon, or system that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality of care for those served by the organization e. Professional practice models illustrate the alignment and integration of nursing practice with the mission, vision, and values that nursing has adapted. Fasoli has noted that autonomy, accountability, professional development, emphasis on high quality care, and delivery models that are patient centered, adaptable, and flexible provide a framework for professional practice models in nursing. Empowerment may come from within, collectively as in work groups, or from the work environment Manonlovich, Nurses who are empowered take control of their practice and participate in decision making at the point of care, thus strengthening a professional practice model and promoting positive patient care outcomes. An example of this empowerment would be that of Nurse M, who heard other nurses on the unit discussing how patients assigned to Nurse J had recently complained of not receiving pain medication when requested. The following day, Nurse M discussed her findings with her nurse manager, who has a reputation for supporting, developing, and empowering her staff. Although Nurse J resigned her position, the nurse manager continued to offer her support and resources to assist in her rehabilitation. Organizational factors, such as those described in this

example, including open and supportive leadership, adequate resources, and professional development empower nurses to act and promote moral courage in the workplace. Shared Governance Shared governance promotes collaborative decision making and shared responsibility; it empowers nurses to act with moral courage by taking ownership of their practice at the point of care. Work environments in which shared governance is firmly embedded facilitate active involvement of frontline staff in the creation of a professional practice model that promotes quality patient care outcomes. In such a situation, out of duty to the patient and to self, the morally courageous nurse will advocate for the patient by initiating conversations with other care providers, consulting with the hospital ethics committee, and utilizing other appropriate resources to engage the family and patient in meaningful discussion that can result in consensus around the goals of care. Nurses practicing in shared governance settings have access to the information and resources they need to make effective decisions, create change, and influence outcomes Hess, Every day nurses and their healthcare colleagues are confronted with challenging situations where effective communication is essential, while at the same time fraught with difficulty. Assertive communication is the act of stating a position with assurance. It is an honest, direct, and appropriate means of communicating that focuses on solving a problem Lachman, The use of assertive communication is imperative not only to patient safety and to quality patient care, but also to invoking the chain of command. Engaging the chain of command both ensures that the appropriate leaders know what is occurring and allows for initiating communication at the level closest to the event, moving the discussion upward as the situation warrants. Just Culture The concepts of effective communication and chain of command are inherent in a position statement recently published by the ANA. In a just culture, individuals are not held accountable for system problems over which they have no control. A just culture recognizes that patient care safety and quality is based on teamwork, communication, and a collaborative work environment ANA, Just culture environments enhance moral courage in the workplace. Leadership Nurse leaders demonstrate moral courage when they oppose work environments that put patient safety at risk. For example, chief nurses act with moral courage when they firmly oppose cost-containment measures, such as nursing layoffs or reductions in healthcare services, that would jeopardize the delivery of safe, competent patient care. Nurse leaders can create environments that support moral courage by clearly providing guidelines for nurses to use when they observe unethical practices and by providing resources, such as ethics committees, shared governance structures, and mentoring opportunities that enable nurses to confront ethical dilemmas in practice Murray, All nurses can demonstrate leadership by role modeling ethical behaviors based on established nursing practice standards. They can also recognize colleagues and peers when they uphold ethical principles and demonstrate moral courage, and work to develop and implement policies and procedures that facilitate effective responses to moral distress at the point of care Murray, Conclusion Nurses who possess moral courage embrace the challenge of transforming the profession and the workplace. They are the nurses who question the premature discharge of an elderly patient with no social support and limited resources, refuse to administer a medication whose efficacy or dosage they question, challenge those who treat others unjustly, or speak up when others remain silent. Nurses who act with moral courage take risks knowing that they may encounter lateral violence, including bullying, harassment, or sabotage, as well as risk of termination. Nurses practicing with moral courage know that addressing these issues is leadership in action, the type of leadership that began with Florence Nightingale â€" who role modeled moral courage on the battlefield, in the classroom, at the bedside, and among legislators in advocating for the rights of patients, colleagues, and humanity. What is our needful thing? To have high principles at the bottom of all. Without this, without having laid our foundation, there is small use in building up our details. This is as if you were to try to nurse without eyes or hand If your foundation is laid in shifting sand, you may build your house, but it will tumble down Ulrich, , p. Nurses have obligations to patients, one another, and the global community to assure optimal health, personal wellbeing, and quality of life for all with whom they come in contact. Both the culture of the profession and the culture of the workplace must be transformed p. This duty exists whether nursing practice occurs at the bedside, in the classroom, in the board room, or in the research setting. Quite simply, the accountability and

responsibility for creating environments that promote moral courage in practice and transform the workplace is an obligation shared by all nurses, in every role, in every specialty, in every setting. Letter to the Editor by Rosario Gallegos.

Chapter 4 : The Moral Reasoning of Nurses Who Work in the Adult Intensive Care Setting

The various methods of describing care, identified as care taxonomy, were all described by the adult intensive care nurses as they discussed dilemmas experienced in professional practice. All nurses, both neonatal and adult intensive care, used the attachment and connection category as they described moral dilemmas [11].

Scores corresponding to the knowledge base of autonomy were positively associated with the level of educational attainment, length of ICU experience, frequency of attendance at continuing education programs, level of work satisfaction, significance of job independence, and perceived status of intensive care nursing Table 4. Previous Section Next Section Discussion We investigated specific indices of autonomy, collaboration, moral distress, and job satisfaction simultaneously in a sample of European intensive care nurses. Our results indicated moderate practice autonomy scores, with lower scores for issues of control over unit organization and policy; moderate moral distress; moderate nurse-physician collaboration and satisfaction with care decisions; and significant differences among participants from different countries for moral distress and nurse-physician collaboration scores. Although differences in autonomy scores among nurses from different countries were not significant, lower levels of autonomy were associated with increased episodes and intensity of moral distress, lower perceived nurse-physician collaboration, and increased intention to resign. The lack of significance despite obvious trends for autonomy in different national groups may be attributed to statistical power limitations and to limitations of the instrument due to the conceptual complexity of autonomy in nursing. Additionally, respondents who had increased levels of autonomy were more likely to report higher levels of collaboration and satisfaction with care decisions and to describe fewer morally distressing situations than were nurses with less autonomy. However, these findings on autonomy should be viewed in the context of the limitations of the methods we used in the study. Further, the country of origin of participants may have influenced the results; approximately one-third of the respondents were from the United Kingdom, Greece, and Italy. Moreover, the use of a convenience sample and the high percentage of head nurses Table 1 might have resulted in the overestimation of autonomy levels, job satisfaction, and notions of collaborative practices. Lack of sample heterogeneity was also a limitation. Further, the results are limited by the self-reported data. Moreover, some ICU environments closely regulate the work of nurses via well-defined guidelines and protocols. In such circumstances, nurses may perceive that the ability to exercise autonomy is limited. An additional limitation is that many participants did not complete the questionnaire in their mother language. Preferences for being autonomous differ among nurses. Nurses with little preference for autonomy may be less satisfied when they gain decision-making influence. In addition, nurses may aspire to different types of decisional authority than other health professionals do. Overall, the participants in our study perceived that they had increased autonomy in decisions about nursing care but not in decisions about unit operation and management, suggesting that the nurses thought they had limited control over their practice. Control over nursing practice and autonomy are distinct concepts. Studies have indicated that control over nursing practice is associated with increased job satisfaction and improved patient outcomes 1 , 34 , 36 and with decreased job-related stress, burnout, and staff turnover. Although low clinical decision-making autonomy has been reported among Hellenic intensive care nurses, 16 the levels of autonomy in our study are difficult to compare with the levels in previous studies because of differences in the instruments used. In a previous study 11 among Finnish ICU nurses in which the investigators used the same instrument we did, trends of autonomy were similar to those in our study. Moral distress is equally a problem and is increasingly prevalent, especially among ICU nurses, because the ICU itself is a stressful environment. Moral distress not only is linked with burnout and job stress but also may adversely affect provision of quality care when nurses become emotionally drained and disengaged. The situations typically involve having to work with unskilled colleagues and the provision of futile or inappropriately aggressive care. Similar to findings in previous studies, 24 , 26 levels of moral distress in our study were moderate. However, the nurses in our study identified activities such

as initiating extraordinary life-saving actions that prolonged the inevitability of death as more distressing than did nurses in previous reports. Differences among countries for this item were significant, and it warrants more study. The higher levels of moral distress reported by nurses from Greece and Germany are interesting and merit further investigation because the findings may reflect the inequality of power relations between nurses and physicians. For example, in Greece and Germany, the transition of nursing education from technically oriented schools to universities is not yet complete, and this situation may undermine the decisional authority of nurses in these countries. Low clinical decision-making autonomy 16 and diminished perceived public image of ICU nurses 45 have been previously reported among intensive care nurses in Greece. Our finding of a negative association between the level of reported autonomy and frequency of moral distress reveals the importance of nursing autonomy as a factor in mediating moral distress. When nurses lack decisional authority over patient care, they may experience moral incongruence. Absence of nurse-physician collaboration is a main source of moral distress. Addressing the quality of nurse-physician collaboration on care decisions may be part of the overall strategy to reduce moral distress. Gutierriez 42 identified the absence of nurse-physician collaboration as a main source of moral distress. In our sample, mean collaboration scores were higher than the scores in a previous investigation 47 in nurses in the United States in which researchers used the same instrument that we used. Moreover, in our study, increased perceived collaboration in and satisfaction with care decisions were associated with lower levels of moral distress. Previous Section Next Section Conclusions and Implications The importance of autonomy, accountability, and collaboration in critical care nursing cannot be overstressed. Similar to recent findings, 34 , 45 our results suggest that nurses think that laypersons do not appreciate the importance of ICU nursing work. Educational practices that empower and promote a critical approach 50 , 51 and engagement in continuous professional development 52 can support recognition of professional autonomy of nurses. However, developing, implementing, and sustaining effective nurse-physician collaboration are also imperative. Various approaches for the enhancement of collaboration have been investigated. Unit-based programs to improve communication 53 and use of multidisciplinary rounds 54 appear to be effective and to result in improved patient outcomes and economic gains. We thank Aniarti and Mr Elio Drigo, especially, for their enthusiastic support throughout the study, for translating the scales into Italian, and for participating in data collection. Tsafou also provided help in data collection.

Chapter 5 : Ethical Reasoning - | Nursing Homework Help Service

Today's healthcare system requires that nurses have strong medical-technical competences and the ability to focus on the ethical dimension of care.

High ethical reasoning ability is one of the main requirements of nursing profession. This ethical reasoning should be improved in nursing student during educational period. It should be further evolved during their independent clinical work as a nurse. Limited evidences are exist about the level of ethical reasoning of nursing students and nurses in Iran. Therefore, the purpose of this study was to compare the ethical reasoning of nursing students and nurses in Tabriz University of Medical Sciences. This descriptive-comparative study was performed on nursing students and nurses who were selected by census. It consists of 6 scenarios. Ethical reasoning score Nursing Principled Thinking NP was the sum of scores of fifth and sixth levels of Kohlberg ethical development questionnaire. The scores varied from 18 to The data were analyzed using SPSS and by descriptive and inferential statistics. Findings Ethical reasoning score of nursing students Conclusion Lower NP scores of nurses comparing with NP scores of nursing students is an alarm for nursing managers and need a special attention. Ethic, Ethical reasoning, Kohlberg, Nurses, Nursing students. The development of moral judgment during nursing education inFinland. Nursing Ethics through the Life Span. Journal of Medical Ethics andHistory. Persian -Burnard P Chapman C Towards a theory of nursing ethics. A comparison of ethical reasoning abilities of senior baccalaureate nursing students and experiencednurses doctoral dissertation. Effect on moral development. A follow up study with new graduate nurses. Journal of Advanced Nursing. Moral reasoning and moral behavior among selected groups of practicing nurses. Moral reasoning of nurses in the work setting dissertation Massachusetts, Boston UniversitySchool of Nursing. A response of hospital nurses. Moral reasoning in male and female nurses: A care perspective dissertation. StateUniversity of New Jersey. Ethical decision making among family therapists and individual therapist. A review of literature. An investigation into the practices nurses use to maintain their moralintegrity dissertation Massachusetts: A multisite qualitative study of ethicalpractice in nursing. Canadian Journal of Nursing. Ethic in preoperative practice- principles and application. Ethics in preoperative practice- patient advocacy.

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Chapter 6 : Nursing | College of Nursing | Creighton University

The expertise required to interpret clinical situations and make clinical judgments is the essence of nursing care and the basis for advancing nursing practice and nursing science. A nurse is caring for a group of clients with diverse cultural backgrounds.

Patricia Benner;1 Ronda G. Clinical reasoning and judgment are examined in relation to other modes of thinking used by clinical nurses in providing quality health care to patients that avoids adverse events and patient harm. The expert performance of nurses is dependent upon continual learning and evaluation of performance. Critical Thinking Nursing education has emphasized critical thinking as an essential nursing skill for more than 50 years. There are several key definitions for critical thinking to consider. The American Philosophical Association APA defined critical thinking as purposeful, self-regulatory judgment that uses cognitive tools such as interpretation, analysis, evaluation, inference, and explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations on which judgment is based. It presupposes assent to rigorous standards of excellence and mindful command of their use. It entails effective communication and problem solving abilities and a commitment to overcome our native egocentrism and sociocentrism. Every clinician must develop rigorous habits of critical thinking, but they cannot escape completely the situatedness and structures of the clinical traditions and practices in which they must make decisions and act quickly in specific clinical situations. Scheffer and Rubenfeld 5 expanded on the APA definition for nurses through a consensus process, resulting in the following definition: Critical thinking in nursing is an essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: This is demonstrated in nursing by clinical judgment, which includes ethical, diagnostic, and therapeutic dimensions and research 7 p. Critical thinking underlies independent and interdependent decision making. Critical thinking includes questioning, analysis, synthesis, interpretation, inference, inductive and deductive reasoning, intuition, application, and creativity 8 p. Course work or ethical experiences should provide the graduate with the knowledge and skills to: Use nursing and other appropriate theories and models, and an appropriate ethical framework; Apply research-based knowledge from nursing and the sciences as the basis for practice; Use clinical judgment and decision-making skills; Engage in self-reflective and collegial dialogue about professional practice; Evaluate nursing care outcomes through the acquisition of data and the questioning of inconsistencies, allowing for the revision of actions and goals; Engage in creative problem solving 8 p. Taken together, these definitions of critical thinking set forth the scope and key elements of thought processes involved in providing clinical care. Exactly how critical thinking is defined will influence how it is taught and to what standard of care nurses will be held accountable. Professional and regulatory bodies in nursing education have required that critical thinking be central to all nursing curricula, but they have not adequately distinguished critical reflection from ethical, clinical, or even creative thinking for decisionmaking or actions required by the clinician. Other essential modes of thought such as clinical reasoning, evaluation of evidence, creative thinking, or the application of well-established standards of practiceâ€”all distinct from critical reflectionâ€”have been subsumed under the rubric of critical thinking. In the nursing education literature, clinical reasoning and judgment are often conflated with critical thinking. The accrediting bodies and nursing scholars have included decisionmaking and action-oriented, practical, ethical, and clinical reasoning in the rubric of critical reflection and thinking. One might say that this harmless semantic confusion is corrected by actual practices, except that students need to understand the distinctions between critical reflection and clinical reasoning, and they need to learn to discern when each is better suited, just as students need to also engage in applying standards, evidence-based practices, and creative thinking. The growing body of research, patient acuity, and complexity of care demand higher-order thinking skills. Critical thinking involves the application of knowledge and experience to identify patient problems and to direct clinical judgments and actions that result in positive patient outcomes. These skills can be cultivated

by educators who display the virtues of critical thinking, including independence of thought, intellectual curiosity, courage, humility, empathy, integrity, perseverance, and fair-mindedness. The emerging paradigm for clinical thinking and cognition is that it is social and dialogical rather than monological and individual. Early warnings of problematic situations are made possible by clinicians comparing their observations to that of other providers. Clinicians form practice communities that create styles of practice, including ways of doing things, communication styles and mechanisms, and shared expectations about performance and expertise of team members. By holding up critical thinking as a large umbrella for different modes of thinking, students can easily misconstrue the logic and purposes of different modes of thinking. Clinicians and scientists alike need multiple thinking strategies, such as critical thinking, clinical judgment, diagnostic reasoning, deliberative rationality, scientific reasoning, dialogue, argument, creative thinking, and so on. Critical Reflection, Critical Reasoning, and Judgment Critical reflection requires that the thinker examine the underlying assumptions and radically question or doubt the validity of arguments, assertions, and even facts of the case. Critical reflective skills are essential for clinicians; however, these skills are not sufficient for the clinician who must decide how to act in particular situations and avoid patient injury. Available research is based upon multiple, taken-for-granted starting points about the general nature of the circulatory system. As such, critical reflection may not provide what is needed for a clinician to act in a situation. This idea can be considered reasonable since critical reflective thinking is not sufficient for good clinical reasoning and judgment. The powers of noticing or perceptual grasp depend upon noticing what is salient and the capacity to respond to the situation. Critical reflection is a crucial professional skill, but it is not the only reasoning skill or logic clinicians require. The ability to think critically uses reflection, induction, deduction, analysis, challenging assumptions, and evaluation of data and information to guide decisionmaking. Critical thinking is inherent in making sound clinical reasoning. The clinician must act in the particular situation and time with the best clinical and scientific knowledge available. The clinician cannot afford to indulge in either ritualistic unexamined knowledge or diagnostic or therapeutic nihilism caused by radical doubt, as in critical reflection, because they must find an intelligent and effective way to think and act in particular clinical situations. Critical reflection skills are essential to assist practitioners to rethink outmoded or even wrong-headed approaches to health care, health promotion, and prevention of illness and complications, especially when new evidence is available. Breakdowns in practice, high failure rates in particular therapies, new diseases, new scientific discoveries, and societal changes call for critical reflection about past assumptions and no-longer-tenable beliefs. Clinical reasoning stands out as a situated, practice-based form of reasoning that requires a background of scientific and technological research-based knowledge about general cases, more so than any particular instance. It also requires practical ability to discern the relevance of the evidence behind general scientific and technical knowledge and how it applies to a particular patient. Situated in a practice setting, clinical reasoning occurs within social relationships or situations involving patient, family, community, and a team of health care providers. The expert clinician situates themselves within a nexus of relationships, with concerns that are bounded by the situation. Expert clinical reasoning is socially engaged with the relationships and concerns of those who are affected by the caregiving situation, and when certain circumstances are present, the adverse event. Expert clinicians also seek an optimal perceptual grasp, one based on understanding and as undistorted as possible, based on an attuned emotional engagement and expert clinical knowledge. However, the practice and practitioners will not be self-improving and vital if they cannot engage in critical reflection on what is not of value, what is outmoded, and what does not work. As evidence evolves and expands, so too must clinical thought. Clinical judgment requires clinical reasoning across time about the particular, and because of the relevance of this immediate historical unfolding, clinical reasoning can be very different from the scientific reasoning used to formulate, conduct, and assess clinical experiments. While scientific reasoning is also socially embedded in a nexus of social relationships and concerns, the goal of detached, critical objectivity used to conduct scientific experiments minimizes the interactive influence of the research on the experiment once it has begun. The scientist is always situated in past and immediate scientific

history, preferring to evaluate static and predetermined points in time e. For example, was the refusal based upon catastrophic thinking, unrealistic fears, misunderstanding, or even clinical depression? Techne, as defined by Aristotle, encompasses the notion of formation of character and habitus 28 as embodied beings. While some aspects of medical and nursing practice fall into the category of techne, much of nursing and medical practice falls outside means-ends rationality and must be governed by concern for doing good or what is best for the patient in particular circumstances, where being in a relationship and discerning particular human concerns at stake guide action. Such a particular clinical situation is necessarily particular, even though many commonalities and similarities with other disease syndromes can be recognized through signs and symptoms and laboratory tests. Phronesis is also dependent on ongoing experiential learning of the practitioner, where knowledge is refined, corrected, or refuted. The Western tradition, with the notable exception of Aristotle, valued knowledge that could be made universal and devalued practical know-how and experiential learning. Descartes codified this preference for formal logic and rational calculation. Aristotle recognized that when knowledge is underdetermined, changeable, and particular, it cannot be turned into the universal or standardized. It must be perceived, discerned, and judged, all of which require experiential learning. In nursing and medicine, perceptual acuity in physical assessment and clinical judgment i. Dewey 32 sought to rescue knowledge gained by practical activity in the world. He identified three flaws in the understanding of experience in Greek philosophy: In practice, nursing and medicine require both techne and phronesis. Aggregated evidence from clinical trials and ongoing working knowledge of pathophysiology, biochemistry, and genomics are essential. Thinking Critically Being able to think critically enables nurses to meet the needs of patients within their context and considering their preferences; meet the needs of patients within the context of uncertainty; consider alternatives, resulting in higher-quality care; 33 and think reflectively, rather than simply accepting statements and performing tasks without significant understanding and evaluation. Clinical decisionmaking is particularly influenced by interpersonal relationships with colleagues, 39 patient conditions, availability of resources, 40 knowledge, and experience. This requires accurate interpretation of patient data that is relevant to the specific patient and situation. As Dunne notes, A practice is not just a surface on which one can display instant virtuosity. It grounds one in a tradition that has been formed through an elaborate development and that exists at any juncture only in the dispositions slowly and perhaps painfully acquired of its recognized practitioners. Clearly Dunne is engaging in critical reflection about the conditions for developing character, skills, and habits for skillful and ethical comportment of practitioners, as well as to act as moral agents for patients so that they and their families receive safe, effective, and compassionate care. Professional socialization or professional values, while necessary, do not adequately address character and skill formation that transform the way the practitioner exists in his or her world, what the practitioner is capable of noticing and responding to, based upon well-established patterns of emotional responses, skills, dispositions to act, and the skills to respond, decide, and act. MacIntyre points out the links between the ongoing development and improvement of practice traditions and the institutions that house them: Lack of justice, lack of truthfulness, lack of courage, lack of the relevant intellectual virtuesâ€”these corrupt traditions, just as they do those institutions and practices which derive their life from the traditions of which they are the contemporary embodiments. To recognize this is of course also to recognize the existence of an additional virtue, one whose importance is perhaps most obvious when it is least present, the virtue of having an adequate sense of the traditions to which one belongs or which confront one. This virtue is not to be confused with any form of conservative antiquarianism; I am not praising those who choose the conventional conservative role of laudator temporis acti. It is rather the case that an adequate sense of tradition manifests itself in a grasp of those future possibilities which the past has made available to the present. Living traditions, just because they continue a not-yet-completed narrative, confront a future whose determinate and determinable character, so far as it possesses any, derives from the past 30 p. It would be impossible to capture all the situated and distributed knowledge outside of actual practice situations and particular patients. However, students can be limited in their inability to convey underdetermined situations

where much of the information is based on perceptions of many aspects of the patient and changes that have occurred over time. Simulations cannot have the sub-cultures formed in practice settings that set the social mood of trust, distrust, competency, limited resources, or other forms of situated possibilities. Experience One of the hallmark studies in nursing providing keen insight into understanding the influence of experience was a qualitative study of adult, pediatric, and neonatal intensive care unit ICU nurses, where the nurses were clustered into advanced beginner, intermediate, and expert level of practice categories. The advanced beginner having up to 6 months of work experience used procedures and protocols to determine which clinical actions were needed. When confronted with a complex patient situation, the advanced beginner felt their practice was unsafe because of a knowledge deficit or because of a knowledge application confusion. The transition from advanced beginners to competent practitioners began when they first had experience with actual clinical situations and could benefit from the knowledge gained from the mistakes of their colleagues. Competent nurses continuously questioned what they saw and heard, feeling an obligation to know more about clinical situations. Beyond that, the proficient nurse acknowledged the changing relevance of clinical situations requiring action beyond what was planned or anticipated. Both competent and proficient nurses that is, intermediate level of practice had at least two years of ICU experience. As Gadamer 29 points out, experience involves a turning around of preconceived notions, preunderstandings, and extends or adds nuances to understanding. Experiential learning requires time and nurturing, but time alone does not ensure experiential learning. Aristotle linked experiential learning to the development of character and moral sensitivities of a person learning a practice. Gadamer, in a late life interview, highlighted the open-endedness and ongoing nature of experiential learning in the following interview response: Being experienced does not mean that one now knows something once and for all and becomes rigid in this knowledge; rather, one becomes more open to new experiences. A person who is experienced is undogmatic.

Chapter 7 : Creating Workplace Environments that Support Moral Courage

Nursing practice is complex, as nurses are challenged by increasingly intricate moral and ethical judgments. Inadequately studied in underrepresented groups in nursing, moral distress is a serious problem internationally for healthcare professionals with deleterious effects to patients, nurses, and.

In lieu of an abstract, here is a brief excerpt of the content: A Selected Bibliography, to Present Doris Mueller Goldstein bio The ethics of nursing is emerging as a discipline distinct from bioethics or medical ethics. Although these areas have many concerns in common, nurses are demonstrating that their perspective can make a unique contribution to ethical debate. An especially dynamic area of discussion within nursing ethics is the philosophy of caring. Jean Watson, a nurse at the University of Colorado Center for Human Caring, also has written extensively on the philosophy of caring. She states that "an ethic of caring has a distinct moral position: Even as the philosophy of caring becomes more predominant, however, nurses today are often drawn away from the caring role by forces prevalent in the modern hospital. A recent study examined the frequency and seriousness of ethical issues encountered in nursing practice IV A, Berger A survey instrument that included 32 potential ethical issues was developed by the authors. Respondents were asked to identify what kinds of issues concerned them and with what frequency, and to indicate what resources were used to cope with these dilemmas. The study found that nurses were frequently faced with inadequate staffing, heroic measures for prolonging life, inappropriate resource allocation, situations where patients are being discussed inappropriately, and coping with irresponsible activity of colleagues. The variety of ethical dilemmas encountered on a daily basis by nurses and their expressed interest in developing a moral grounding for the profession of [End Page] nursing, along with increased attention to ethical issues in nursing education have led to an explosion in the literature on these topics. In the preparation of this bibliography over 1, citations were retrieved in computer searches of various databases: What is offered here is a small sampling of that literature. Books and special issues of periodicals are briefly annotated, but citations to articles are simply arranged by broad subject, and within that, alphabetically by author. The subcategories reflect the topics receiving the most discussion in current literature. This bibliography updates "The Ethics of Nursing: Books Australian Nursing Federation. Georges Road, postal code The National Professional Development Committee of Australia fostered the publication of a second volume of papers on nursing ethics. Several appendices represent difficult-to-obtain documents, such as the RANF Royal Australian Nursing Federation position statements on terminal care, AIDS and occupational health, professional practice problems, and conscientious objection. Nursing Ethics Through the Life Span. Following an extensive review of the moral foundations of decision making in nursing, the authors take the reader through a chronology of nursing ethics issues as they occur in the human life span, beginning with the procreative family period and concluding with the end of life. Each chapter contains discussion questionsâ€”an aid to educators using this as a textbook. Benjamin, Martin, and Curtis, Joy. Oxford University Press, An overview of the nature of ethical inquiry and theory is followed by You are not currently authenticated. View freely available titles: