



Facilitated Ethics Conversations

A Novel Program for Managing Moral Distress in Bedside Nursing Staff

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A B S T R A C T

Moral distress is a prominent problem for bedside nurses, and workable solutions for managing the toll it takes are needed. We created a unit-based ethics conversations program in response to nurses' need to find ways to deal with their moral distress. We review our initial experiences in conducting more than 100 such facilitated conversations in a large hospital system.

Contact with patients who are suffering is a given for anyone who works in healthcare, but it is especially prominent for nurses. Because of their close proximity and extended exposure to patients, nurses often gain early insight into futility of care.¹ Many factors conspire to limit nurses' opportunity to take time to reflect on the burden they bear being ever present in providing care to patients, particularly in ethically challenging situations.

Moral distress is a feeling that occurs when one believes that he/she knows the correct thing to do but is unable to pursue the right course of action. Moral distress among nurses is a growing problem that has been linked to poor performance, to burnout, and indeed to nurses leaving jobs and leaving the profession altogether.²⁻⁸ Given the current critical shortage of bedside nurses and the growing projected future shortage, we must make reducing nurses' moral distress a

priority if we hope to meet the growing demand for trained nurses.⁹

Because nurses are more likely to use resources that are unit

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based,¹⁰⁻¹² staff of the Charles Warren Fairbanks Center for Medical Ethics (FCME) at Clarian Health (CH) created a new program in 2005 known as unit-based ethics conversations (UBECs) in response to an identified need for meaningful conversation among staff nurses about the ethical issues they face in routine clinical practice and which are felt to contribute to moral distress. The mission of UBECs is to create an environment with morally open space where reflective dialogue and sharing of experiential narratives are encouraged. The goals of the program are to increase participants' abilities and confidence in dealing with ethically challenging situations and to provide an environment free of judgment for disclosure and frank discussion of morally troubling situations. To date, our group has facilitated more than 100 such UBECs in 21 different clinical units. We report our initial experiences with the development of the program, describe what we have learned to date about the impact of these discussions, and summarize our goals for evaluating the program more formally.

Hospital Environment

Clarian Health was created from a consolidation of 3 large Indianapolis hospitals, Methodist Hospital, Indiana University Hospital, and the James Whitcomb Riley Hospital for Children. The 3 hospitals, operated as a single hospital under Indiana law, include 986 adult beds and 448 pediatric beds. This system is the State of Indiana's only tertiary-care, academic referral center, and James Whitcomb Riley Hospital for Children is the only comprehensive children's hospital in the state of Indiana. There are more than 11,000 employees, including over 4,000 nurses. In 2004, CH became Indiana's first Magnet hospital system.

Charles Warren Fairbanks Center for Medical Ethics

The Charles Warren FCME was established in June 2002, with endowment funding provided by the Richard M. Fairbanks Foundation of Indianapolis and start-up funding provided by the Methodist Health Foundation and CH. Since late 2004, the FCME has actively developed service, education, and research programs with a focus on the ethical lives of healthcare professionals. In 2007, the Fairbanks Program in Nursing Ethics was founded, and its first program leader was hired.

Program Development and Meeting Format

The initial development of the UBEC program in early 2005 arose out of the recognition that, within this large and diverse care environment, the thousands of practic-

ing bedside nurses working at CH had no organized forum for processing the ethical challenges they faced daily. The first UBECs began in the neonatal and pediatric intensive care units as a series of informal meetings, occurring at times selected by the staff and nursing managers of these units. The intention of the meetings was not for the facilitators to teach a formal ethics curriculum or content, but rather to provide a forum for processing and discussing the ethical issues with which the staff were struggling. The facilitators began each session by asking if any of the nursing staff had a recent case they wanted to discuss. When no case came immediately to mind, facilitators asked if the participants wanted to discuss any issues that cross-cut several cases. During the first 2 years of the program's existence, the primary facilitators included an oncologist-ethicist (P.R.H.) and a licensed clinical social worker (P.D.B.), who is a long-term member of the Hospital Ethics Committee and a faculty member at the ethics center. A nurse-ethicist (L.D.W.) assumed leadership of the program in 2007 and now facilitates the majority of the conversations. During the period in which the physician-ethicist was the primary facilitator, we noticed that participants were less spontaneous in early meetings but became less guarded over a period of 3 or 4 sessions. We have theorized that, because a great deal of nurses' ethical experiences are shaped or affected by interstaff relationships and communication, particularly with physicians,^{13,14} each group of nurses needed time to build trust with the physician-facilitator to trust that the environment was "safe" and that issues that might be perceived as negative or critical of physicians could be voiced without fear of negative responses. Thus, over time, the conversations have become more comfortable and more open.

Unit-based ethics conversations focused initially on pediatric intensive care units and were not generally advertised or promoted. Word spread informally among other nurses and nursing unit managers who contacted our group to schedule regular sessions for their units too. Thus, the UBEC initiative expanded to include the adult oncology units, adult medical and surgical intensive care units, labor and delivery and the high-risk obstetrical areas, the operating room scrub and circulating nursing staff, and others. Although we found in the course of these UBECs with diverse nursing units that each group faced issues specific to its clinical patient groups, we also discovered many issues that deeply affect nurses working in all specialty areas of our large hospital system. We will address some of these findings below.

Techniques of facilitation: A Case Example

The goal of the UBEC program has been to encourage open and honest conversation about the ethical issues bedside nursing staff face in the ordinary course of

caring for patients. Conversations are organized without a specific agenda and with no didactic goals. Facilitators begin each UBEC with a prompting statement such as "Does anyone have a case he/she would like to discuss?" or "Have any ethical issues arisen since the last time we met?" In some sessions, participants have agreed ahead of time on the case to present for discussion. In others, a specific case is mentioned; frequently, several participants have cared for the patient involved in the case. In some sessions, issues that affect the unit's practice across cases serve as the basis for the conversation.

Facilitators use standard techniques of group facilitation, including active and reflective listening and validation of feelings.¹⁵ Frequently, participants find it difficult to articulate the exact nature of the problem at the heart of nurses' distress, so facilitators may use focused questions to probe carefully for the essential aspects of the problem. Commonly, we have found that it requires extensive probing and exploration to help participants uncover and put into words the issues that actually underlie their distress. An early example of this phenomenon was an emotional meeting with members of the newborn intensive care unit nursing staff, nursing management, and extracorporeal membrane oxygenation (ECMO) team. The case involved a neonate with a complex constellation of anomalies, including congenital heart disease. Although the baby had reached a stage at which she had multisystem organ failure, and the care team held out essentially no hope of meaningful recovery, the parents' insistence on continued aggressive care led to initiation of ECMO therapy as a last ditch effort to support the baby's cardiac and respiratory failure. After several days of ECMO and the development of significant complications, the baby died after withdrawal of therapy. As the description unfolded, the UBEC participants' moral distress was palpable in the room, but it took patient facilitative work before the true issue could be given voice. After several minutes of focused questions, validation of feelings, and gentle probing by the facilitator, a nurse was able to say, "We felt like we were doing procedures on a dead baby. It felt like we were desecrating her body." In this case, the conversation helped the nurses articulate their feelings in terms of a violation of the code of nurses that obliges nurses to respect their patients even in death.

We find it useful and instructive to summarize the issues under discussion using ethical terms for the issues that seem most important or troubling. For example, "It sounds like you were in conflict between your ethical obligation to act in the best interests of your patient and your professional duty to follow orders." We have found that once participating staff members feel comfortable in this group environment and trust they are safe to speak their minds around the facilitators, there is free exchange of feelings, emotions, information, and insight. In rare instances, a case has led a staff member to become flooded with emotions and express reluctance to continue participation in UBECs. In such cases, our

practice is to enlist the individualized support of the distressed employee's unit manager to ensure the individual receives adequate support and follow-up.

Stimulating Discussion

The facilitators have found several techniques to be useful in stimulating productive conversation and reflection among the nursing staff participants.

1. **Clarifying details.** Assuring that the "whole story" is presented is an important aspect of all ethics case analysis. It is common that several participants are only partially informed about the details of the case under discussion and that such partial understandings contribute in important ways to feelings of distress and, in some cases, to judgments that do not follow logically from a deeper understanding of the facts. Early clarification of the medical facts, psychosocial and family issues, and other key information is very important. This is done without a chart or medical records review, but by iterative discussion with participating staff members. Commonly, multiple staff members participating in a given UBEC are familiar with parts of the patient's case. By probing for details and inviting other staff to provide missing parts of the story, we attempt to demonstrate that a clear understanding of the facts of the case is essential to appreciating the core issues and identifying the real causes of distress.
2. **"Pushing" participants.** Gently "pushing" participants to reflect out loud and articulate the central ethical issues of each case under discussion leads to productive discussion. For example, nurses may either say explicitly or demonstrate through voice tone or body language that they are extremely troubled by a given case; however, at the beginning of the case discussion, they may not be able to articulate what is most bothering them. To get at the core concern, the facilitator identifies the intent to "push" them by asking permission to probe a bit further. For example, "Can I just push you a little bit on this issue?" Such statements build trust and allow the participants to remain in control of the direction of the conversation, or to stop it if it becomes too emotionally difficult.
3. **"Polling."** Stopping a case discussion at a controversial point and going around the room to poll participants for their opinions invite participants to consider on which side of an issue they find themselves at that moment and stimulate participation from all individuals present. For example, the group hears a case involving family members facing a withdrawal of life-prolonging therapy decision for a loved one who lacks decision-making capacity. The family members ask the nurse, "What would you do?" The facilitators use this opportunity to poll participants about how they would respond to this question. The "answers" allow the group to identify variations in individual nurses'

approaches and learn from each other. Sharing divergent opinions leads both to productive discussions of how to handle such a common question and to identification of the ethical issues it raises (eg, How do you provide a meaningful answer to this question and yet respect the autonomy of the patient and surrogate decision makers?).

4. **Reflective and supportive statements.** Careful listening fosters an atmosphere of trust and mutual respect. Listening attentively to what a participant is saying and then reflectively summarizing the meaning of the comment back to the speaker demonstrate interest and respect. A facilitator's statement, "So what I hear you saying is... [followed by a reflective summary]," encourages the participant to clarify the meaning of his/her comment, to amplify some part of it, or provide a more nuanced understanding of what he/she means. Equally, we have found that nonjudgmental supportive statements are essential in creating an environment of emotional safety and trust within the group, for example, naming the emotion underlying a participant's comment and then saying, "Providing that kind of care under those circumstances must have been very hard for you." When there are disagreements among members over strongly held positions, we find it helpful to acknowledge that disagreements in conclusions can ethically derive from valid and deeply held beliefs.
5. **Resist answers and solutions.** One of the important lessons we have learned in facilitating UBECs over the past 3 years is that, as in all clinical ethics, we rarely find a tidy "answer" or a completely acceptable resolution to a given ethically charged situation. Initially, staff nurses frequently had the misconception that the participating ethicists had the "answers" and would tell the group what the answer or solution should be at the close of the discussion. Rather than finding a single answer, resolution of difficult ethical dilemmas nearly always involves reaching clarity about the potential choices and their ethical implications, and then ordering them in a way that allows choice of a pathway that seems most right. Frequently, this means finding the "least bad" solution from among the potential, ethically acceptable alternatives. So, more frequently than not, we end the UBECs not with "the right answer," but with the sense that the conversation has "worked" because it led to clarity about the issues underlying the participants' distress. Participants emerge with a better sense of how divergent views on the case derive from equally valid considerations, and with some conviction that respectful discussion of different views and of the feelings a case has engendered has been an important and valuable exercise.
6. **Best practices.** The facilitators intentionally invite discussion of strategies for handling difficult situations. For example, in cases where nurses were caring for patients undergoing nonbeneficial, aggressive treatments, and surrogates seemed to be making decisions to continue such treatments because of a lack of

communication about prognosis or lack of clear limitations to therapy, we ask how nurses intervened: did they try to bridge communication with the medical staff or with family? Did they take it upon themselves to fill in the apparent information gaps? Did they make recommendations themselves? Did they consult with their nursing colleagues? This technique of exploring what the participating nurses believe to be best practices in difficult situations leads to highly productive interactions in which novice and expert nurses share approaches and debate the merits of each approach. In this way, novice nurses hear from expert nurses more adaptive or successful strategies for handling difficult situations. Thus, we are able to arrive at strategies for managing thorny practice problems that seem to us to be "best practices": consistent with ethical principles and with core nursing values.

Complement to a Formal Ethics Consultation: Case Examples

During UBECs, the facilitators are careful to clarify that the UBEC discussion is not a formal ethics consultation and not intended to replace ethics consultation. Unlike formal ethics consultations, UBEC discussions do not include a formal chart review, documentation in the patient's chart, or interviews with other key stakeholders, most notably the patient or patient's family.

However, we find that UBECs both complement and intersect with the activities of the Ethics Consultation Service at CH. For example UBEC facilitators may recognize that an active case under discussion would benefit from formal ethics consultation and recommend to participating nurses that a consult be requested. Because our system endorses open access to ethics consultation, nurses may directly request ethics help by referring the case to the Ethics Consultation Service. Conversely, the Ethics Consultation Service frequently encounters very challenging cases in which the ethics consultants recommend that further follow-up with the unit nursing staff is important, either to provide a forum for further reflection and processing, or to clarify ethical or legal perspectives. In these cases, we initiate a follow-up UBEC to provide a forum for such discussion to "close the loop" with nursing staff following the formal ethics consultation.

The facilitators for UBECs all serve as members of the institution's Ethics Committee and Ethics Consultation Service. While maintaining necessary role boundaries, the UBEC facilitators are able to serve as information conduits between groups familiar with the same cases. As members of the Ethics Committee and Ethics Consultation Service, UBEC facilitators participate in regular meetings where formal ethics consultations are reviewed. These meetings provide UBEC facilitators with valuable information about ethics

consultations completed on difficult cases that may be brought up by staff nurses in future UBECs. Unit-based ethics conversation facilitators are also able to share the perspective of staff nurses whose distress, processed in a UBEC, has provided the impetus for a case to be referred for ethics consultation.

For example, during a regular UBEC for the neurology critical care unit, nurses identified a particularly troubling case of a young man who had sustained a devastating neurological injury as the result of uncontrolled hypertension. The nurses described the struggle between the patient's wife, who refused to acknowledge the grim prognosis provided by the medical team, and the patient's extended family who accepted the information from physicians and wished to discontinue aggressive, life-sustaining interventions. The nurses expressed empathy with the extended family who felt powerless to overrule the wishes of the patient's wife and acknowledged frustration with the apparently irresolvable conflict. The facilitator, aware that there had been a formal ethics consultation for this case, was able to help the UBEC group focus on ethical issues pertinent to the consultation and identify useful strategies to use in future similar cases.

In another case, nurses on an oncology unit expressed their distress surrounding the care of a patient whose family was directing the patient's care in ways consistent with the family's cultural beliefs, but alien to the nurses' commitment to patient autonomy. The family insisted that the staff not reveal to the patient the severity of her disease (terminal with brain metastases). The nurses were upset at not being able to assist the patient in planning for her death, particularly because she had small children who visited daily at the bedside. The UBEC facilitator helped participants analyze important ethical issues: the obligation to tell the truth to patients versus obligations to honor a patient's cultural beliefs and traditions. The UBEC discussion explored the limits of compromise and identified under what circumstances it would be appropriate to request a formal ethics consultation. The UBEC provided the nurses an opportunity to think through their distress and identify the nature of their conflict. Subsequently, the nurses from that unit requested a formal ethics consultation, based in part on their ability to objectively identify the nature of their distress and conflict through the UBEC discussion.

Common Themes

Several common ethical issues have been evident in UBEC discussions across diverse clinical units. A frequently occurring theme has been nonbeneficial treatment of patients who are unlikely to survive to discharge. We have heard countless descriptions of patients of all ages who continue to receive life-prolonging therapy beyond the point at which the care team has come to a consensus that the patient is unlikely to survive and

that further life-prolonging therapy will not be beneficial. Common reasons for this include family reluctance to agree to treatment limitations, and communication gaps between the care team and patients and/or their surrogates. This theme is a source of enormous frustration, sorrow, and moral distress for bedside nurses. Their frustration frequently stems from feelings of powerlessness to move the situation forward, from recognition that system factors beyond their control are at work, and from the emotional exhaustion of being "the nurse in the middle."¹⁶

Another common theme concerns informed consent. For instance, operating room staff nurses have shared examples of preoperative encounters with patients who did not seem aware of the full implications of the procedures they were about to undergo or seemed to lack decisional capacity in ways that might affect their ability to make autonomous decisions. Nurses state that they rarely bring these concerns to the attention of attending surgeons, rationalizing that operating room nurses were not present for all the previous discussions between patients and their care teams and may not have enough perspective or knowledge to judge how consent was obtained. Thus, such instances remain a source of distress.

Sometimes, the nurses offer cases representing true ethical dilemmas, rather than complex, nuanced cases in which several ethical issues are at work. For example, newborn intensive care unit staff were troubled by a newborn with ambiguous genitalia, whose genital malformations were not conducive to reconstruction that would be consistent with the baby's chromosomal sex. The staff struggled greatly to try to balance the decision of how to assign the "final" sex to this patient given the complexity and profound long-term implications of such a decision.

Finally, communication inadequacies or gaps are frequent sources of distress for bedside nursing staff. Some communication problems stem from interdisciplinary or hierarchical issues (eg, physician staff who do not adequately communicate goals or plans of care to nursing staff), and some stem from organizational challenges (eg, complex patients cared for by multiple, specialized teams, each of whom considers one aspect of the patient's care, but no one of whom seems to be in charge of the global direction of care).¹⁷ It is common for us to discover in the course of a UBEC that bedside nurses are the members of the care team best positioned to bridge communication gaps among specialists or between doctors and family.

Obstacles and Limitations

Timing and logistical barriers present the most practical obstacles to regular UBECs in all units. Although each clinical unit decides on the timing of the meetings themselves, we have found that there is really no ideal time for all who want to attend. We have tried doing sessions

at morning shift change, theorizing that night-shift nurses would be able to participate at the end of their shift. This has only rarely worked, because night-shift nurses are exhausted by morning or need to get home to take care of other responsibilities. Day-shift nurses coming on are eager to move quickly to patient assessments and treatment. Lunch meetings work best for units that use a staggered lunch break, so that nurses can come at least to part of the UBEC during their lunch. Other units have preferred mid-morning and mid-afternoon times. Although we have found that unit managers and shift coordinators most frequently attend UBECs, bedside staff who have an interest in ethics or who have attended and found the meetings productive become regular participants. Frequently, bedside staff are simply too busy with patient care responsibilities to be able to attend for a whole hour.

We have not reached any firm conclusions about the “dose” of UBECs that works best. Nursing units where staff are interested in engaging frequently encountered ethical issues seem to benefit from monthly or every-other-month meetings. We have noticed that having every-other-month meetings for 6 to 12 months works for these units, but once the most troublesome and frequent ethical issues are processed, then less frequent meetings are more likely to hold the staff’s interest. Until our formal evaluation studies are completed, we have concluded through experience that every-other-month UBECs work best for most nursing units. We strongly believe, however, that it is *regular* participation over time that leads to the benefits.

Group interaction is equally dynamic with both very small numbers of participants (3–4 participants with 1–2 facilitators) or larger numbers (eg, 20–25 participants). We have also observed that discussion is enriched

through participation of others who collaborate with the nurses in patient care (eg, physicians, social workers, respiratory therapists, chaplains). Because we have organized these sessions to be completely open to any interested members of the staff or care teams, the composition of any given group’s meeting is variable.

Although we have not yet completed a formal evaluation of the program, we have the impression that group interaction is different when physician staff are present. The conversations seem more guarded when physicians are present, and deference to physicians’ opinions or personalities can interfere with more open airing of views and opinions. Occasionally, physicians have monopolized discussion, making it more difficult for nurses and others to present their own views. We have observed that nurses in particular seem to be more reluctant to speak openly when the physicians they work with are present. Balancing the open access model of UBECs with the effects that physician presence seems to have on discussion is clearly a challenge demanding future work and reflection. Determining the optimum frequency for conducting UBECs and exploring the effects of physician presence on the nature and outcomes of UBECs will both be areas of future intense study for our group.

Program Evaluation

We believe UBECs may be an important step in the continued development of moral agency of participants by empowering them to take action as advocates for their patients even during ethically challenging situations and by providing an ongoing forum for engaging problems with the help of trained facilitators. We hope to demonstrate real changes in nurses’ capacity to live with and manage their moral distress by virtue of participation in UBECs. We plan to take the lessons we have learned and will learn through more systematic evaluation and create a “train the trainer” program for UBEC facilitators so that the program can be exported and implemented by others.

We have learned several important lessons so far from this novel program.

1. Bedside nurses are hungry for opportunities to process the ethical challenges that affect their daily lives and are generally grateful that others recognize that their work includes substantial ethical dimensions.
2. Common ethical experiences cross-cut units and practice areas of nursing: for example, the problem of non-beneficial treatments, issues surrounding communication about difficult information, staking out territory as a patient advocate in a hierarchical system. There are no easy solutions to any of these problems, but the opportunity to share experiences and learn from others is valuable.
3. Training or deep experience in ethics on the part of the facilitator seems to be a vital component of successful

<p>The objective of providing UBECs is to provide a safe environment to discuss morally troubling issues that arise during patient care. If you have ever attended a UBEC, please complete the survey below.</p>	
1. Did the session meet its' intended objective (described above)?	YES NO
2. What were your expectations for attending a UBEC?	
3. Were your expectations met?	YES NO
4. When you attended UBEC did you have the opportunity to discuss (tell a story) about a challenging situations in your nursing practice?	YES NO
5. Did the UBEC you attended help you to address ethical issues in your practice?	YES NO
6. What was helpful about the UBEC?	
7. What was not helpful about the UBEC?	
8. Do you have any suggestions for how the UBEC might be improved?	
9. Would you recommend UBECs to a peer?	YES NO
10. As a result of attending UBEC do you feel better able to manage ethically challenging situations?	YES NO

Figure 1 • Unit-based ethics conversation Attendee Survey.

Tell me about your experience(s) participating in UBEC:

1. What was helpful about the UBEC?
2. What was not helpful about the UBEC?
3. What effect on later conversations do you think your participation in the UBEC had?
Prompts: changes in attitude, behavior
 - a. Do you feel better prepared to handle ethical issues?
 - b. Are you able to define your role in these types of situations?
 - c. Did it change how you perceived yourself as being able to address issues (make a difference) in ethically challenging situations?
 - d. Do you feel better able to act as a patient's advocate (speak up) in ethically challenging situations?
 - e. Did it change what you did when you found yourself in similar situations?
4. Do you feel you understand key ethical principles?
 - a. Are you able to put into words (articulate) sources of your moral distress?
5. Since participating in the UBEC have you had an opportunity to apply things discussed during the UBEC (faced an ethically challenging situation)?

Figure 2 • UBEC focus group questions.

leadership of UBECs with bedside nursing staff. Many of the issues that cause nurses frustration are not, specifically, ethical issues, but the facilitator's acumen in helping participants to recognize and, indeed, to name and analyze those that are ethical issues is an important component of the program's impact.

The challenge of conducting a formal evaluation of a fluid program such as the UBEC without changing the impact of the program drove the design of the methods we are using to evaluate the program. Nurses who work on units where UBECs are offered will be invited to complete a short evaluative survey of the program. Nurses who complete the short survey will be given the opportunity to participate in focus group discussions about their UBEC experience. Attendees of UBECs, regardless of nursing unit, will be eligible to participate in focus group discussions about their experience attending UBEC. The UBEC Attendee Survey (Figure 1) was developed using standard questions for program evaluation. The questions for the focus group were developed after reviewing relevant literature and through our experience with conducting UBECs (Figure 2). The aim of the questions is to draw out participants' impressions of participating in the UBEC.

The UBEC attendance surveys will provide data on satisfaction with the program and whether nurses felt it helped them to manage ethically challenging situations they encounter in clinical practice. This focus group study will provide more detailed, qualitative information about participants' experience with UBECs.

Finally, future efforts will also be aimed at developing a curriculum to train facilitators, so that the reach of the program can be extended.

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