Notice to CE enrollees:
A closed-book, multiple-choice examination following this article tests your understanding of the following objectives:

1. Describe the impact of ethical conflict in the intensive care unit (ICU) for patients, families, and health care workers.
2. Describe risk factors and early warning signs of potential ethical conflicts with ICU patients.
3. Explain key results of ethical risk factor screening for critical care nurses.

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Background  Ethical conflicts, often leading to poor teamwork and moral distress, are very challenging to patients, patients’ families, and health care providers. A proactive approach to ethical conflicts may improve patient care outcomes.

Objectives  To examine acceptability and feasibility of an ethics screening and early intervention tool for use by nurses caring for critically ill patients.

Methods  Twenty-eight nurses in 2 medical centers applied the ethics screening tool to 55 patient situations. Nurses assessed situations for risk factors and early indicators of ethical conflicts and analyzed level of risk. At study completion, nurses participated in focus group discussions about the tool’s benefits and challenges. Frequency counts were performed on risk factors and early indicators of ethical conflicts. Content analysis was used on written explanations regarding high-, medium-, and low-risk situations and on focus group data.

Results  Older patients with multiple comorbid conditions and aggressive treatments were frequently assessed to be at risk for ethical conflicts. Nurses who witnessed patients’ suffering and deterioration were likely to initiate the screening process. The most prominent family risk factors included unrealistic expectations and adamancy about treatment. The most prominent early indicators were signs of patients’ suffering, unrealistic expectations, and providers’ own moral distress. High-risk situations averaged a greater number of risk factors and early indicators than did medium- and low-risk situations. Certain risk factors featured prominently in high-risk situations.

Conclusions  A phenomenon of shared suffering emerged from the study and signifies the importance of relational strategies such as routine family conferences and ethics consultation.

(American Journal of Critical Care. 2015;24:248-257)
Ethical conflicts are among the most challenging situations faced by patients with life-threatening conditions, their families, health care providers, and the health care system. In complex clinical situations, different moral perspectives are expected and can improve the plan of care. However, if health care providers avoid discussion about ethical concerns or systems fail to provide opportunities to resolve disagreements, ethical conflicts often result in suffering of patients. Ethical conflicts represent divergent values and are usually accompanied by strong and sometimes troubling emotions. Furthermore, ethical conflicts can lead to providers’ moral distress, which the American Association of Critical-Care Nurses identifies as critically important. In a consensus statement, the American College of Critical Care Medicine asserted that effective team communication plays a crucial role in preventing and managing ethical conflicts during end-of-life care. In this article, we describe a research project that pilot tested a new ethics screening and early intervention tool to improve communication and prevent potentially harmful conflicts and moral distress.

**Background**

Current ethical conflicts reflect advanced medical technology, consumers’ expectations of medical care, tension between patient autonomy and medically appropriate treatment, shifts in health care financing, and limited economic and workforce resources. Sources of ethical conflict include poor communication, competing values and interests, divergent goals, and disruptive behavior. Whether they occur between providers and patients’ families or among health care teams themselves, ethical conflicts in intensive care units (ICUs) are prevalent. In the Conflicus Study, 71.6% of 7498 ICU nurses and physicians in 24 countries reported a perceived ethical conflict in the week before the survey. Swetz et al reviewed 255 ethics consultations and reported that most cases involved multiple ethical conflicts including staff disagreement with the plan of care (76%), end-of-life issues (60%), and futility concerns (54%); 40% involved ICU situations.

Ethical conflicts are among the most challenging situations faced by patients with life-threatening conditions, their families, health care providers, and the health care system. In complex clinical situations, different moral perspectives are expected and can improve the plan of care. However, if health care providers avoid discussion about ethical concerns or systems fail to provide opportunities to resolve disagreements, ethical conflicts often result in suffering of patients. Ethical conflicts represent divergent values and are usually accompanied by strong and sometimes troubling emotions. Furthermore, ethical conflicts can lead to providers’ moral distress, which the American Association of Critical-Care Nurses identifies as critically important. In a consensus statement, the American College of Critical Care Medicine asserted that effective team communication plays a crucial role in preventing and managing ethical conflicts during end-of-life care. In this article, we describe a research project that pilot tested a new ethics screening and early intervention tool to improve communication and prevent potentially harmful conflicts and moral distress.

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Nurses’ moral distress is associated with absenteeism, burnout, and leaving the profession.

Nurses’ moral distress is associated with absenteeism, burnout, and leaving the profession. The negative effects of ethical conflicts are widespread for patients, patients’ families, and health care providers. Quality care and patient safety are threatened when health care providers are burdened by stressful ethical conflicts that erode interpersonal trust, compromise working relationships, and fragment care. Furthermore, these compromised relationships increase patients’ mortality and morbidity54,66,47 and organizational costs.41,48 Ethical conflicts can also delay treatment decisions4 and increase the risk for family conflict.24,49

Ethical conflicts contribute to moral distress,20,50 Jameton51 introduced the concept of moral distress as an experience in which a person is constrained by stressful ethical conflicts that erode interpersonal trust, compromise working relationships, and fragment care.1,24,39-45 Furthermore, these compromised relationships increase patients’ mortality and morbidity44,46,47 and organizational costs.41,48 Moral distress not only affects individual behavior but also the workplace environment.52-58 For example, distressed health care providers can experience decreased job satisfaction,39-41 unsettling physical symptoms such as insomnia and headaches, and disruptive psychological symptoms such as loss of confidence and self-worth.26 Moreover, nurses’ moral distress has been associated with absenteeism, burnout, intentions to quit, and leaving the profession.62-65 These consequences can lead to inadequate staffing, which in turn, is linked to unfavorable patient outcomes such as hospital-acquired infections.66 Lingering effects of providers’ moral distress can lead to moral desensitization,69 harmful workplace climates,23 and suffering of patients and their families.23 The health system itself is financially affected when moral distress drives nurses and other providers to decreases their work engagement and productivity.23,39,67,68

Method

This feasibility study was conducted at Mayo Clinic in Rochester, Minnesota and the University of California Los Angeles Medical Center. Two institutional review boards approved the study. The aim was to assess utility and acceptability of an ethics screening tool for clinical practice.

Development of the Ethics Screening and Early Intervention Tool

We used the results of a critical incident study to construct the tool. Pavlish et al69 asked nurses to identify risk factors for and early indicators of ethical dilemmas and conflicts. We selected the most prevalent responses and constructed the tool accordingly. Five critical care, oncology, and ethics experts assessed the tool for content clarity and relevance. The tool’s first section required nurses to assess clinical situations for which risk factors and early indicators were evident and to analyze the level of risk (low, medium, high) that the situation was likely to develop into an ethical conflict. Next, nurses identified appropriate follow-up actions. Finally, nurses were asked to appraise the risk of negative consequences for themselves if they initiated action to address the potential conflict.

Participants

We recruited oncology and ICU nurses via flyers; 28 bedside nurses participated, 14 from each site. Most (n = 25) worked in ICUs. Five men and 23 women participated; they had a mean of 9.65 years of clinical experience. Educational preparation included 1 diploma, 4 associate’s degrees, 21 baccalaureate degrees, and 2 master’s degrees. Half of the participants reported ethics education as part of their nursing curriculum, 5 reported attending ethics conferences, and 9 reported little or no ethics training. Most nurses were white; 1 nurse was African American, 1 was Asian American, and 1 was a Pacific Islander.

Study Procedures and Data Collection

Before ethics screening started, participants attended a 4-hour ethics workshop where researchers reviewed ethical responsibilities, a case study with guidelines on raising concerns, and orientation to the ethics tool and study procedures. Researchers in both sites used the same training materials and discussion outline. Because the workshop was interactive, many participants raised their own questions and provided their own examples. The result was a structured, interactive dialogue about ethical responsibilities and concerns. After the workshop, we asked participants to apply the screening tool in clinical practice for 3 months. All but one nurse initiated the tool when an ethics-related issue seemed pertinent. One ICU nurse chose to change his use of the tool after 6 weeks of the study and applied the tool on every patient he cared for. Because his use of the tool varied from that of other participants, we analyzed and reported his data separately.

When applying the tool, nurses also responded to a brief questionnaire with 2 major sections: (1) ethics situation such as patients’ diagnoses, general condition, and time required for screening, and (2)
threatening illness and patients’ vulnerabilities such as advanced age, diminished capacity, and inability to speak English were the risk factors most prevalently identified at both sites. Nurses across both settings also identified “family adamancy about aspects of patient care” and “unrealistic expectations” as prominent risk factors. The most prominent early indicators of ethical conflicts were the same in both settings and included “signs of patient suffering” and “signs of unrealistic expectations” followed closely by indicators of nurses’ own moral distress.

Risk Level Assessment

The screening tool asked nurses to analyze whether situations were high, medium, or low risk for ethical conflicts and briefly explain their reasoning. High-risk situations averaged more risk factors and early indicators than medium- and low-risk situations (10.17 vs 7.46 and 1.9, respectively). A few risk factors were especially prevalent in the high-risk versus medium- and low-risk categories: (1) patients who were imminently dying (50% vs 16.7% and 3%, respectively) and (2) situations that involved family disagreements with care (50% vs 10.7% and 3.4%, respectively). Signs of moral distress among caregivers occurred in both high-risk and medium-risk situations, but were more likely to occur in high-risk situations (67.8%) than in medium-risk situations (58.3%). Nurses never indicated signs of moral distress in low-risk situations. Signs of conflict were also more prevalent in high-risk situations (57%) than in medium-risk (41.6%) and low-risk (12.9%) situations. Signs of patients’ suffering were also prevalent in both high-risk and medium-risk situations, but rare in low-risk situations.

Nurses’ narrated rationale for assigning risk revealed some patterns. For example, nurses consistently reasoned that high-risk situations included decidedly aggressive treatments in patients with advanced illness or poor prognosis; violation of patients’ advance directives; distressed family members, especially if accompanied by disagreement with the plan of care; and health care providers’ own moral distress. Some nurses also reasoned that seriously ill patients without family or other supports were high risk. Situations that included uncertainty with plan of care or delays in making difficult decisions tended to be reasoned as medium risk and worth monitoring.
Screening Tool Benefits and Limitations

At the conclusion of the 3-month data collection period, we held focus groups and distributed a final survey. Nurses indicated that the screening tool’s primary benefit was its capacity to clarify “murky” issues in complicated clinical situations. For example, one nurse commented that the tool validated the participant’s concerns and proved “it wasn’t just some crazy nurse thinking a gut feeling.” Other nurses suggested that the tool “brings the conversation to the table” so everyone is “on the same page.” Some nurses commented that the tool empowered them to “push for an ethical plan of care” and also promoted teamwork, which relieved their moral distress. Other benefits included “the tool promotes nurses’ confidence,” and “starts conversations early enough

### Table 1

Frequency of situational factors

<table>
<thead>
<tr>
<th>Situational factors</th>
<th>Site A (30 patients)</th>
<th>Site B (25 patients)</th>
<th>Totals (55 patients)</th>
<th>Nurse A (42 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ age, y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>31-50</td>
<td>6</td>
<td>8</td>
<td>14</td>
<td>13</td>
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<td>51-65</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>8</td>
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<td>66-80</td>
<td>13</td>
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<td>18</td>
<td>14</td>
</tr>
<tr>
<td>≥ 81</td>
<td>4</td>
<td>7</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>No age noted</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patients’ primary diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>9</td>
<td>7</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Metastatic cancer</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Heart failure</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Liver failure</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Brain injury (trauma, vascular)</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Respiratory failure</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Complications after surgery</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Other[b]</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>None listed</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Patients’ health condition[c]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deteriorating</td>
<td>14</td>
<td>20</td>
<td>34</td>
<td>6</td>
</tr>
<tr>
<td>Suffering distressing symptom</td>
<td>3</td>
<td>14</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Cognitively impaired</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>New diagnosis</td>
<td>8</td>
<td>6</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Imminently dying</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Other (prolonged illnesses)</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Events that prompted screening[c]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient suffering</td>
<td>9</td>
<td>18</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Vulnerable patient</td>
<td>6</td>
<td>18</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Family statement</td>
<td>8</td>
<td>11</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Code status</td>
<td>7</td>
<td>10</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Admission to unit</td>
<td>11</td>
<td>4</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Change in patient’s condition</td>
<td>8</td>
<td>7</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Health care provider’s statement</td>
<td>10</td>
<td>4</td>
<td>14</td>
<td>5</td>
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<tr>
<td>Concern for patient’s autonomy</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Patient’s statement</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>36d</td>
</tr>
<tr>
<td>Minutes required for screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 5</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>6-10</td>
<td>9</td>
<td>13</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>11-15</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>≥ 16</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>None listed</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Note:
- Nurse screened all patients he cared for instead of only when an ethical issue seemed likely.
- Cocaine overdose, cerebral palsy, systemic inflammatory response syndrome.
- Multiple responses in each situation.
- Daily assessment.
to prevent demoralizing crisis situations.” Nurses also believed that the tool was convenient, easy to use, and would be acceptable to complete on a daily basis.

Nurses also provided suggestions for improving the screening tool. For example, nurses suggested that ethics screening should be multidisciplinary and include the whole team in discussing different perspectives about care. Several nurses stated that the tool should be applied soon after a patient’s admission and regularly thereafter. Nurses frequently compared the ethics tool to skin and fall risk assessments; they suggested that the tool should be computerized, easily accessible, and expected as a standard of care. Others encouraged development of more objective measures for distinguishing between low-, medium-, and high-risk situations. Some nurses also indicated that the tool needed to provide more guidance for follow-up action. A few believed that the tool should include some automatic triggers. For example, one nurse stated, “If you were to create something that would automatically [trigger] a consult or some other action, it would decrease the possibility for interpersonal conflict.”

Discussion

Results indicate that nurses are aware of certain risk factors and early signs that potentiate ethical conflicts. Given the time that nurses spend at patients’ bedsides, it is not surprising that these nurses were especially sensitized to risk factors related to patients and patients’ families. Peter and Liaschenko72 claimed that proximity to patients helps nurses understand their moral responsibilities but does not necessarily provide the resources and power to formulate a response. Participants in our study verified this assertion when describing their experiences with patients and families.

### Table 2

**Frequency of risk factors and early indicators**

<table>
<thead>
<tr>
<th>Risk factor totals (checked all that apply)</th>
<th>Site A (30 patients)</th>
<th>Site B (25 patients)</th>
<th>Totals (55 patients)</th>
<th>Nurse A (42 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual risk factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient vulnerability</td>
<td>73</td>
<td>80</td>
<td>153</td>
<td>64</td>
</tr>
<tr>
<td>Life-threatening illness</td>
<td>19</td>
<td>23</td>
<td>42</td>
<td>39</td>
</tr>
<tr>
<td>Failed treatments</td>
<td>23</td>
<td>15</td>
<td>38</td>
<td>7</td>
</tr>
<tr>
<td>Unnecessary suffering</td>
<td>12</td>
<td>16</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Imminently dying</td>
<td>10</td>
<td>16</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td><strong>Family risk factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adamancy about aspects of care or unrealistic expectations</td>
<td>45</td>
<td>52</td>
<td>97</td>
<td>16</td>
</tr>
<tr>
<td>Uncertainty about plan of care</td>
<td>16</td>
<td>17</td>
<td>33</td>
<td>3</td>
</tr>
<tr>
<td>Disagreement with plan of care</td>
<td>11</td>
<td>11</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>Conflict between family members about plan of care</td>
<td>7</td>
<td>13</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Other (no family present; family underpresence)</td>
<td>9</td>
<td>7</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td><strong>Health care team risk factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for cohesive plan of care</td>
<td>26</td>
<td>29</td>
<td>55</td>
<td>12</td>
</tr>
<tr>
<td>Conflict among health care team about plan of care</td>
<td>12</td>
<td>10</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>Divergence of views regarding prognosis</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Standard of care concern</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Other (false hope; uncertainty about capacity)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td><strong>Health care system risk factors</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclear or absent ethics policies</td>
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<td>10</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>8</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td><strong>Multilevel risk factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of clear, specific communication</td>
<td>10</td>
<td>13</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>12</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>157</td>
<td>184</td>
<td>341</td>
<td>100</td>
</tr>
<tr>
<td><strong>Early indicators (checked all that apply)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs of patient suffering (prolonged, unrelieved pain)</td>
<td>16</td>
<td>20</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>Signs of unrealistic expectations (unwavering belief in patient recovery)</td>
<td>17</td>
<td>18</td>
<td>35</td>
<td>4</td>
</tr>
<tr>
<td>Signs of nurses’ moral distress (believe treatment is not helpful, causes suffering)</td>
<td>17</td>
<td>13</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>Signs of conflict (disagreements, different opinions)</td>
<td>14</td>
<td>11</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>Signs of poor communication (avoid end-of-life and other difficult discussions)</td>
<td>7</td>
<td>13</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Signs of ethics violation (disrespect autonomy, right to information/standard care)</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Other (surrogate decision maker has diminished capacity, patient has no support)</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>78</td>
<td>80</td>
<td>158</td>
<td>39</td>
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distress with difficult situations. For example, a particularly surprising finding that we reported in a recent article was that despite nurses’ comments about the empowering benefits of the screening tool, several nurses still remained silent about their concerns. Nurses described power structures and unit norms that often dictate who gets to say what in these complex situations. From this, we reasoned that the screening tool strengthened nurses’ internal voices but did not necessarily encourage them to voice their concerns to others. We believe that this finding also explains why nurses suggested objective measures for determining risk level, more guidance for follow-up action, and automatic triggers for certain actions such as ethics consultation.

Nurses identified multiple risk factors and early indicators of ethical conflicts in all high- and medium-risk situations. Furthermore, they had little trouble distinguishing low-risk from medium-risk and high-risk situations, although some indicated that they had difficulty distinguishing between medium- and high-risk situations. This may indicate that these complex situations are very fluid and have multiple, influencing variables with uncertain outcomes. Additionally, not much is known about the characteristics of ethically difficult situations or the effectiveness of follow-up actions. A few studies exist. For example, Schneiderman and colleagues found in a multicenter randomized trial that ethics consultations were effective in decreasing conflicts. Browning found that nurses who reported being involved in patient care conferences were less likely to experience moral distress, which is often associated with ethical conflicts. In an intervention led by ICU nurses, researchers found improved surrogate decision making and urged nurses to become more involved in collaborative discussions about ethical issues.

In our research, the top 3 indicators of high risk for ethical conflicts in both settings pertained to patients’ suffering, providers’ distress, and unrealistic expectations among patients’ families. When families are distressed and adamant and providers believe that treatments are harmful and increase needless suffering, patients ultimately endure the consequences. This triangle of suffering may reflect a phenomenon of shared suffering. If suffering is seen as an individual experience, as it often is, feelings of isolation and being trapped in silence can result. In contrast, if suffering is viewed as a shared experience, then easing suffering could also include relational treatments such as timely and periodic family care conferences that not only provide information but also create an atmosphere of trust by being present to one another, listening, and acknowledging grief. In addition, the team might benefit from collaborative work with clinical ethics and palliative care. Relational interventions that decrease the emotional suffering of critically ill patients and their families as they confront important treatment decisions need to be researched.

Limitations

Results are limited by the small, nonrepresentative sample. Participants who volunteered might be more interested and sensitive to ethical issues in clinical practice, which could skew the results. The 3-month time period also limits any conclusions about sustainability of the benefits of using the tool. Our deciding not to require nurses to implement follow-up actions that were included on the tool limits our findings on the tool’s usefulness and acceptability. Future research should determine the effectiveness of the tool by measuring outcomes such as stress and perceptions of care among patients and their families, providers’ moral distress, and team collaboration.

Conclusion

Four key results from our study seem particularly relevant to critical care nurses. First, we learned that seriously ill patients are at risk for ethical conflicts and that all patients may benefit from being initially and periodically evaluated for that risk. Screening all critically ill patients would lead to early identification of particular medium- and high-risk situations and prompt early action that could modify risk and mitigate suffering for both patients and caregivers. Second, we learned that using an ethics screening and early intervention tool is feasible but needs to include a team-based approach, objective indicators, and clear guidelines for follow-up actions. More research on specific actions such as relational support that mitigates or prevents ethical conflict is needed. Third, we learned that nurses should be involved in ethics-related discussions, but ethical concerns are sometimes perceived by critical care nurses as too risky to voice. To address this risk, we need to create systems that set a high standard for collaboration in ethics conversations for all ICU patients. Critical care researchers indicate that nurses are well positioned to initiate and strengthen teamwork in ethically complex situations. Specific approaches for early nursing assessment that leads
to collaborative action need to be developed and tested. Finally, we learned that suffering is a complex, shared experience that has significant consequences for patient, family, and the care team. Responding to shared suffering through early recognition of moral disagreements and implementing relational approaches to address differences could mitigate conflict and mounting distrust, providing an opportunity for authentic dialogue, deeper understandings, and good outcomes.

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1. Which of the following statements reflects an ethical conflict?
   a. A patient with stage IV lung cancer has determined his code status as "do not resuscitate and do not intubate (DNR/UNI)."
   b. A patient with stage IV lung cancer has agreed to palliative radiation therapy.
   c. A patient with stage IV lung cancer has become unable to make his own decisions and the surrogate decision maker wishes to reverse the DNR/UNI status that was decided previously by the patient.
   d. A patient with stage IV lung cancer understands that chemotherapy will not be curative.

2. Which of the following strategies is considered to be the most effective to prevent and manage ethical conflicts in the intensive care unit (ICU)?
   a. Ethical consults to override decisions for aggressive treatment
   b. Authentic leadership and appropriate staffing
   c. Effective team communication
d. Palliative care consults

3. Ted, a longtime ICU night nurse, has asked to work day shift after he was involved in a difficult situation where he disagreed with the aggressive plan of care for a patient with end-stage liver disease who required weeks of treatment and an ethics consult. Which of the following reflects that Ted may be experiencing moral distress?
   a. Ted has developed insomnia and recurrent headaches after this situation.
   b. Ted has expressed the professional goal to become involved in the hospital’s ethics committee.
   c. Ted has collegial relationships with the nurses and physicians on the night shift and wants to expand this to the day-shift colleagues.
   d. Ted has had several difficult conversations with the attending physician regarding end-of-life care for patients.

4. What is the basis for “prognostic conflict?”
   a. There are differing opinions between providers about the diagnosis.
   b. There are 2 different treatment regimens for the diagnosis.
   c. There is a poor prognosis and palliative care is initiated.
   d. There are different perspectives regarding anticipated benefit from aggressive treatment.

5. Which of the following statements most accurately reflects the relationship between low-, medium-, and high-risk ethical conflicts as perceived by the nurses in the study?
   a. It was often difficult for nurses to distinguish between low-risk and high-risk patient situations.
   c. Unit norms and power structures had significant influence on which risk level was scored.
   d. Low-risk situations were screened as such due to the presence of structured family meetings.

6. Application of the ethics screening tool was found to identify which of the following risk factor categories as the most prevalent?
   a. Health care team
   b. Health care system
   c. Family
d. Individual

7. Which of the following statements most accurately reflects the identification of patients that prompted the use of the ethics screening tool in this study?
   a. Young patients with terminal disease processes
   b. Elderly patients with life-threatening sepsis or organ failure
   c. Elderly patients without family support
d. Middle-aged patients with traumatic brain injury

8. Which of the following statements most accurately reflects the analysis of risk factors by the nurses in the study?
   a. Nurses indicated moral distress among caregivers in low-, medium-, and high-risk situations.
   b. Signs of patient suffering were prevalent in high- and medium-risk situations.
   c. Family disagreements regarding care were prevalent in high- and medium-risk situations.
   d. Seriously ill patients without family were considered low risk for ethical conflict.

9. The nurses in the study found which of the following to be the primary benefit of an ethics screening tool?
   a. Promotes nursing confidence to relieve moral distress
   b. Identifies what needs to be done for ethical issues
   c. Promotes teamwork surrounding identification of ethical issues
d. Empowers nurses by clarifying issues in complicated clinical situations

10. The authors concluded which of the following key results regarding ethics screening?
    a. A nurse-driven screening tool is sufficient to guide early interventions.
    b. Routine screening of all critically ill patients could lead to earlier ethical action.
    c. Team-based collaboration for screening is only helpful for seriously ill patients.
    d. Moral distress is eliminated by ethics screenings.

11. Which of the following were identified by the authors as the top 3 indicators of high risk for ethical conflicts?
    a. Providers’ distress, violation of patients’ advance directives, concern for patients’ autonomy
    b. Unrealistic expectations from patients’ families, violation of patients’ advance directives, patients’ advanced illness
    c. Unrealistic expectations from patients’ families, providers’ distress, and patients’ suffering.
    d. Providers’ distress, patients’ suffering, patients’ advanced illness.

12. Which of the following statements most accurately reflects the authors’ view of suffering in ethical conflicts?
    a. Easing shared suffering may be accomplished through family care conferences and grief acknowledgement.
    b. Relational interventions to relieve suffering are well studied.
    c. An atmosphere of trust is violated in shared suffering.
    d. Clinical ethics and palliative care are the only avenues by which to alleviate shared suffering.
Screening Situations for Risk of Ethical Conflicts: A Pilot Study
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