Liberty University John W. Rawlings School of Divinity

Ethical Decision Making in Nursing Practice: The Impact on Moral Distress

A Thesis Project Submitted to

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By

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Thesis Project Approval Sheet

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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There is significant research that indicates nurses working in a hospital setting experience moral distress while caring for their patients. While there are many barriers that prevent nurses from overcoming moral distress and moving toward moral resilience, this research project focused on eliminating barriers that nurses face in making good ethical, moral, biblical decisions. The research methodology for this project was qualitative, interpretive, and longitudinal. There was an initial interview with five participant nurses at Ellis Medicine regarding their knowledge of ethics in healthcare and moral distress. The researcher then provided an education program for participant nurses to increase their knowledge of ethics in healthcare and moral distress and provide tools to help them overcome barriers in taking action to make good ethical, moral, biblical decisions, which will help build moral resilience. The nurses took a survey following the education program to measure the impact of the intervention. The results of the study support the hypothesis that nurses face barriers in making good ethical, moral, biblical decisions in their practice, and education can help alleviate barriers along with helping to build moral resilience.

Keywords: healthcare, nursing, chaplain, ethics, moral distress, moral resilience

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Abbreviations

ACPE   *Association of Clinical Pastoral Education*

BCC   *Board Certified Chaplain*

CITI   *Collaborative Training Institute Initiative*

CPSP   *College of Pastoral Supervision and Psychotherapy*

Dr.   *Doctor; Physician*

ED   *Emergency Department*

EMU   *Eastern Mennonite University*

ICU   *Intensive Care Unit*

IRB   *Institutional Review Board*

MDS   *Moral Distress Scale*

RN   *Registered Nurse*

SCA   *Spiritual Care Association*

Chapter 1

Introduction

As medical interventions on humans become increasingly more complicated, so do the knowledge, skill, and stress of nurses caring for their patients. Nurses spend more time with patients in the hospital setting than any other discipline. Nurses develop close relationships with families of patients and often have moral distress when families make ill-informed decisions on behalf of their loved ones. Nurses also have moral distress when they face barriers as a result of healthcare policy, regulation, law, and systemic dysfunction. The hypothesis of this paper is that nurses will be able to decrease moral distress and gain moral resilience if they are able to break through barriers that limit their ability to make good ethical, moral, biblical decisions in their nursing practices.

Robichaux says, "A clinical healthcare ethicist needs to have a broad range of knowledge to bring to the consult. This includes knowing about ethical theories, communication skills, law, mediation, process of a consult, religion, as well as history of bioethics and clinical ethics consultation."[1] While nurses are not clinical healthcare ethicists, they do need to have a solid understanding of how to recognize an ethical dilemma, basic ethical theories, how to intervene in order to temper an ethical situation, and when to make a referral to an ethics committee. Competence and confidence in ethical decision making will benefit the nurse and the patient they are caring for.

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[1] Catherine Robichaux, *Ethical Competence in Nursing Practice: Competencies, Skills, Decision-Making*, (New York, NY: Springer Publishing Company, LLC, 2017), 124.

Ministry Context

The ministry context of this paper is a hospital setting where nurses and chaplains work side-by-side on a daily basis. Nurses engage in a healing ministry, even though they may not call it ministry. O'Brien makes a strong case for the practice of nursing as a vocation rather than simply a job.[2] O'Brien's model of sacred covenant for nursing practice could prove to be very useful for nurses struggling to make good ethical, moral, biblical decisions in their practice of nursing.

Sacred covenant gives biblical foundation to a nurse's vocation and role in healthcare. Some nursing schools have grounded their teaching model in sacred covenant. The school of nursing at Eastern Mennonite University makes it clear that their nursing program is grounded in sacred covenant.[3] EMU says, "The sacred covenant is based on both faith and high professional standards, on bringing people to wholeness and healing. The EMU nursing program emphasizes service, empathy, agape love, empowerment, and the nurse-patient relationship."[4] The sacred covenant model of nursing places spirituality and theology over business and consumerism in healthcare. "The sacred covenant approach to patients is different from a consumer model that emphasizes the business aspects of healthcare and views the patient as a customer without taking into account the patient's gifts."[5]

Revered as the founder of modern-day nursing, Florence Nightingale discerned her work in nursing as a call from God. "She was 17 and in her private notes she wrote, 'God spoke to me

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[2] Mary Elizabeth O'Brien, *Spirituality in Nursing* (Sudbury: Jones & Bartlett Learning, LLC, 2017).

[3] "Sacred Covenant Model of Nursing," EMU in Virginia, accessed January 31, 2020. https://emu.edu/nursing/covenant.

[4] Ibid.

[5] Ibid.

and called me to His service'."[6] Nightingale struggled with uncertainty about whether she was fulfilling God's calling of her to nursing; her family was not supportive at first. Nightingale eventually won the approval of her family and was able to follow her calling. She served God through nursing praxis more than she did in theory. Nightingale's work was a blend of science and theology.

Bedside nursing is now very task driven and, as a profession, is much more science based than it is theology centered. Every day nurses carry the burden of more complicated and dangerous medications, legal and regulatory requirements, electronic medical record documentation, and demands from misinformed patients and dysfunctional, argumentative families. On top of these burdens is the challenge to provide the best quality of care in the face of moral distress. These burdens take away from a nurse's ability to care for the whole person. Under the weight of these burdens, nurses struggle to make good ethical, moral, biblical decisions.

No doubt, most people who go into the field of nursing do so because they care about their brothers and sisters in need, and most likely do feel some deep sense of a calling to serve God through nursing. However, with the unreasonable number of practical demands heaped upon nurses, they have little time to do theological reflection on their work. Chaplains can be of great assistance to nurses through a ministry of presence, prayer, and encouragement, but many hospitals are cutting rather than adding to clinical chaplain staffing as a result of the rising cost of healthcare. This puts nurses at an even higher risk, because a primary resource of chaplains to help them in making good ethical, moral, biblical decisions is slowly deteriorating. Healthcare chaplains are experts in assessing, intervening, and creating positive spiritual health outcomes for

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[6] Susan Rakoczy, "Florence Nightingale: Discernment as Trusting Experience," *HTS Teologiese Studies / Theological Studies,* 74 (3) (2018), 1.

patients, families, and staff. It is the responsibility of clinical chaplains and their advocates to ensure healthcare administrators know the value clinical chaplaincy can add to the total care of patients, families, and healthcare staff.

Healthcare administrators often fill the chaplain gap with volunteers from local faith communities. While volunteers in pastoral care departments are very helpful in assisting well-trained clinical chaplains, a volunteer does not have the same education, training, skills, experience, and, most of all, competencies as a board-certified clinical chaplain. Board-certified clinical chaplains are accountable to a code of ethics through their certifying organization, while a volunteer chaplain is not. Additionally, board-certified chaplains provide ministry though the lens of evidence-based practice, a high degree of knowledge of the healthcare system, and development of valuable, trusting relationships with nurses, physicians, and administrators in their ministry context.

The decision to reduce, or sometimes even eliminate pastoral care departments in a hospital setting is often made in a vacuum due to financial stress. Pastoral care departments are vulnerable targets because, on the surface, they are a non-revenue producing expense to the healthcare organization. However, administrators often fail to see the impact pastoral care departments have on their revenue when they turn a blind-eye to the work chaplains do in meeting the total needs of patients, families, and staff. Further, in an attempt to hold on to board-certified chaplain services, Stirewalt et al. say that hospitals try to save precious financial resources by demoting clinically trained chaplains and ethicists from a director role to a manager or coordinator role.[7] When chaplains do not have a director seat at the table, the theological voice

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[7] F. Keith Stirewalt, and Barbara Patten, Is Hospital Keeping Spiritual Care Promises in Mission Statement, *Medical Ethics Advisor,* 32 (9) (2016).

for all faith traditions that may support nurses, especially in making good ethical, moral, biblical

decisions in the care they provide, is absent and diminishes quality of care provided.

Patten advocates for the voice of chaplains at the healthcare ethics table:

> This is only possible if the chaplain's professional skill set is recognized and valued by
> the health system, however. Basic professional trust and respect among the disciplines
> determines how ethical policies and practices are shaped. Patten says chaplains have
> something unique to contribute: They can see the whole scenario. This comes into play if
> staff experience moral distress due to disagreement on the plan of care. Another
> discipline might choose to dismiss the moral distress, focus on the rights and durable
> power of attorney, and interpret that an ethics consult is not necessary. The chaplain
> could invite the staff to discuss their feelings of moral distress. This becomes a learning
> moment for all disciplines involved—to return to the health systems' mission and values
> statement as the foundation of the ethical process.[8]

Overall, nurses want to provide high-quality healthcare and treat the whole person in their

practice. When administrators are prompted to look at how board-certified clinical chaplains play

a central role in fulfilling their mission of high-quality, compassionate healthcare, they also will

create space for nurses to draw upon the expertise of the chaplain to address ethical issues that

create moral distress for them. Communication is central to creating a space for nurses to have

the resources they need for improving their ability to make good ethical, moral, biblical

decisions.

Houghton discusses two communication styles that have an impact on healthcare

decisions.[9] Collectivist-oriented communication happens when other stakeholders have a voice

in the healthcare decision, usually resulting from cultural norms of the patient and their extended

family. Extended family members, clergy, and chaplains may be invited to offer their opinion in

healthcare decisions. Individualist-oriented decision making happens more often in the United

States healthcare system, because of the strong emphasis given to personal responsibility and

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[8] Stirewalt and Patten, *Is Hospital Keeping Spiritual Care Promises in Mission Statement*, 3.

[9] Catherine Robichaux, *Ethical Competence in Nursing Practice: Competencies, Skills, Decision-Making*.

accountability. With the increase in diverse cultural norms making their way into the United States from other countries across the globe, there will be an increase in the diversity of communication styles in the healthcare system.

Rather than attempt to impose a communication and decision-making style on patients, families, and staff in the healthcare system, it is more productive to work with patients, families, and staff on a case-by-case basis, with an open mind about what communication style best suits their needs. Chaplains spend a great amount of time learning about the cultural norms of patients, families, and healthcare staff, and can help nurses grow in their knowledge and ability to communicate in an increasingly pluralistic society. When nurses gain knowledge, understanding, wisdom, and theological insight, they will be able to lessen their moral distress by making better ethical, moral, biblical decisions in their everyday care of patients and families.

Robichaux says, "Although recognition of moral distress is essential, developing and implementing interventions to reduce its impact is critical."[10] Robichaux goes on to examine the causes of moral distress in nursing. Robichaux finds in her research there are personal and professional causes of moral distress, as well as organizational causes. She aligns the personal and professional factors with protecting position or reputation, lack of ethical knowledge/sensitivity, perceived powerlessness, past experiences, and emotional stability. She aligns organizational factors with deficient ethical climate, fear of reprisal for actions, lack of ethical leadership, limited ethics resources, inadequate/incompetent staff, bullying, lateral violence, incivility, and workplace violence.[11]

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[10] Robichaux, *Ethical Competence in Nursing Practice: Competencies, Skills, Decision-Making*, 77.

[11] Ibid., 105–106.

Robichaux presents substantive research and proposed interventions to address ethical dilemmas that lead to moral distress in nursing practice. However, her research does not include enough evaluation of how religious beliefs, practices, and understanding have an impact on moral distress. This is where a theology-based project to evaluate ethical, moral, biblical decision making in nursing practice may lead to theologically, spiritually based interventions to alleviate moral distress through moral resilience.

Problem Presented

The problem this project addressed is that nurses face barriers in making good ethical, moral, biblical decisions at Ellis Medicine. The problem of nurses facing barriers in good ethical, moral, biblical decision making is not isolated at Ellis Medicine. Erlen hypothesizes that moral distress has a negative impact on staffing of nurses and nurses' ability to provide the highest level of care across the spectrum of nursing.[12] Erlen raises a good question that has great influence on the problem of nurses' ability to make good ethical, moral, biblical decisions when providing care to patients. Erlen asks, "To whom do nurses owe their loyalty? Is the patient, the physician, or the system their primary concern? Nurses have a quick response to this question. To honor their commitment to society, the primary accountability is always to the patient."[13] Generally, while nurses may have a quick response stating their loyalty is to their patients, their loyalty is challenged and interfered with because of systemic restraints, power structures in the medical profession, and an overall lack of knowledge in how to respond to moral or ethical dilemmas.

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[12] Judith A. Erlen, "Moral Distress," *Orthopaedic Nursing,* 20 (2) (2001), 76–80.

[13] Ibid., 77.

Nurses continue to rank as the highest trusted professionals in a 2018 Gallup survey.[14] The Gallup survey suggests there is a dominant social agreement in the United States that nurses are to be trusted and are trusted as the professional who spends the most time giving the most hands-on care to a patient. If nurses are the most trusted profession in society, why is the medical system structured such that administrators and physicians frequently rank above nurses in setting policy and do not give full measure to the bedside nurses' professional opinions? Rozario says burnout, moral resilience, and moral injury are "wicked problems" in healthcare.[15] According to Rozario, there are many negative, cultural factors in healthcare that lead to burnout; he dismisses the idea that burnout is a personal issue in healthcare. If nurses are a part of a system and culture that lead to burnout, there is doubt they will have the perseverance and energy to address ethical dilemmas in patient care, which will then lead to the additional burden of moral distress.

Example of Moral Distress in Nursing

Job-related stress and disagreement with physicians and family members of patients are prime examples of moral distress in nursing. Jameton notes that disagreements between nurses and physicians in treatment planning for patients appear in literature even prior to the time of Nightingale.

> The more standard dilemmas remained relevant, but the dilemmas of distress shifted issues from the region of what is right for the patient to the dilemmas of putting a nursing perspective across in a stratified, bureaucratic environment where it was not the nurse's place to determine the direction of patient care, nor to assert moral declarations ex cathedra about the goals of hospital care.[16]

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[14] Susie Demarinis, "Nurses Outpace Other Professions for Honesty and Ethics Again," *Explore* 15 (3) (2019), 175–77.

[15] Duncan Rozario, "Burnout, Resilience and Moral Injury: How the Wicked Problems of Health Care Defy Solutions, Yet Require Innovative Strategies in the Modern Era," *Canadian Journal of Surgery* 62, no. 4 (2019), E7.

[16] Andrew Jameton, "A Reflection on Moral Distress in Nursing Together with a Current Application of the Concept," *Journal of Bioethical Inquiry* 10, no. 3 (2013), 298.

An elderly patient on a ventilator in an ICU of a hospital for several weeks will experience skin breakdown and develop wounds, potentially all over their body. The nurse assigned to such a patient is responsible for carrying out the plan of care. The nurse will tend to the wounds and may see them worsen. Often times these wounds are so severe and deep, the nurse can see the patient's bones exposed. The family may insist on continuing mechanical ventilation even when they have been told that continuing medical interventions will only prolong suffering and death for the patient. The nurse and the doctor may have disagreements about how to address the morally distressing issue with the family. The bureaucratic structure of the healthcare system often prevents nurses from full participation in medical decision making.

When a nurse is unable to participate fully and communicate their professional judgment to a patient's family and the physician, they are left to witness unnecessary pain, suffering, and a slow dying process for their patient. The nurse can be a great benefit to discussions with families in such circumstances. Unfortunately, nurses end up in moral distress because they are unable to do what is right and just for their patients.

Purpose Statement

The purpose of this project is to help nurses at Ellis Medicine overcome barriers in making ethical, moral, biblical decisions. There is significant research that indicates moral distress is present when nurses are unable to make ethical, moral, biblical decisions. The research includes numerous suggestions on how the healthcare system can make changes and improve nurses' ability to make ethical, moral, biblical decisions. At the core of all suggested improvements is nursing education on how to develop moral resilience.

Andrew Jameton first analyzed moral distress in 1984. Gutierrez says, "Jameton, a philosopher, was the first person known to analyze nurses' experiences with moral conflicts and

coined the term moral distress. Jameton defined moral distress as the feelings and experiences which result from a moral conflict where one knows the correct action to take but constraints prevent implementation of this action."[17] With the age of technology, there are many more medical interventions to cure people, but along with these curative interventions comes the ability to keep people alive in a state of pain and suffering that does not contribute to quality of life, but only prolongs the dying process. It is in this area of healthcare where nurses experience the most challenges with ethical, moral, biblical decision making.

Health care chaplains are in a unique position to provide leadership and education to nurses to help them develop moral resilience. Guthrie says chaplains can facilitate conversation and training with nurses and other healthcare providers through a pastoral care model, so they have a deeper understanding of what moral distress is.[18] The model Guthrie suggests is similar to the clinical pastoral education model of action and reflection. Development of an action, reflection training program for nurses will create an opportunity for them to grow in their understanding of how to make better ethical, moral, biblical decisions. The hypothesis is that they will be able to develop a higher level of moral resilience, which will lead to a higher quality of care for their patients along with better physical, mental, and spiritual health for themselves.

Basic Assumptions

In the course of this research project, the primary assumption is that people who go into the field of nursing do so because they feel a strong need, or even a calling to take care of other people, and they want to provide the best quality of care. Clearly, there may be some people who

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[17] Karen M. Gutierrez, "Critical Care Nurses Perceptions of and Responses to Moral Distress," *Dimensions of Critical Care Nursing* 24, no. 5 (2005), 229–41.

[18] Michael Guthrie, "A Health Care Chaplains Pastoral Response to Moral Distress," *Journal of Health Care Chaplaincy* 20 (1) (2014), 3–15.

enter the field for other reasons and see their work as simply a job, but this is likely a slim minority. The majority of caring, compassionate nurses will pressure the minority that do not share those traits out of the field.

If people go into the field of nursing because of a strong desire to take care of other people, then it may also be assumed that nurses want to make good ethical, moral decisions, and have moral resilience rather than moral distress. The nursing workforce is diverse. Therefore, it is assumed that not all nurses will identify with the Christian tradition and want to include biblical decision making as part of their ethical, moral reflection. However, it is assumed that all nurses will respect the right of others to draw upon their religious beliefs in ethical, moral decision making and desire to have some understanding of Christian, ethical decision making.

Regarding policy, regulatory, and legal restraints, it is assumed that nurses respect and adhere to the nursing practice requirements imposed. As a basic example, it is assumed that all nurses follow policy and regulations when acting on doctor's orders, administering medication, and participating in invasive medical procedures. Failure to adhere to these restraints and requirements would put a nurse's license to practice at risk.

Definitions

Biblical Theology:

> The discipline that describes the progressive revelation found in Scripture by examining the theology of its various groupings (e.g., the theology of the Pentateuch; the theology of the Synoptic Gospels). Biblical theology also traces the numerous themes in these groupings and notes their development over time (e.g., worship using altars, worship in the tabernacle and temple, worship in spirit and truth). Biblical theology as a Christocentric approach to Scripture is also quite common. Though referred to as "biblical," this theology is not alone in having Scripture as its source; the same is true of exegetical and systematic theology.[19]

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[19] Gregg R. Allison, *The Baker Compact Dictionary of Theological Terms*, (Grand Rapids, MI: Baker Books, a division of Baker Publishing Group, 2016).

Clinical Chaplain:

A person who has a master of divinity degree, or equivalent, has completed four units of clinical pastoral education (CPE), and has completed all the requirements to be certified by a board certifying agency, such as the College of Pastoral Supervision and Psychotherapy, the Association for Clinical Pastoral Education, or the Spiritual Care Association.

Covenant:

A structured relationship between God and his people, consisting of typical features. A covenant (1) is unilateral, initiated by God alone; (2) creates a structured relationship, or formalizes an already existing relationship, between God and his partners; (3) features binding obligations on the part of God, who commits himself to be God and do certain things, and on the part of the partners, who commit themselves to be faithful and obedient to the covenant terms; and (4) involves covenantal signs or the swearing of oaths. Biblical covenants are the Adamic, Noahic, Abrahamic, old (or Mosaic), Davidic, and new covenants.[20]

Doctor:

Someone who is qualified in medicine and treats people who are ill.[21]

Ethics:

The discipline that studies moral matters. Ethics (from Gk. ēthikos, "habit") focuses on the nature, knowledge, and determination of moral principles; what is right and wrong; and moral obligation. Deontological ethics is the ethics of duty: one does the right and avoids doing the wrong because it is one's duty to do so. Teleological or consequentialist ethics is the ethics of consequences: one does the right and avoids doing the wrong because the former actions produce good consequences and the latter produce harmful consequences. Virtue ethics focuses on promoting right habits (e.g., justice) and avoiding vices (e.g., pride). See also epistemology; metaphysics.[22]

Moral Arguments:

With respect to the doctrine of God, a category of rational arguments for God's existence. As a posteriori arguments, they are based on experience, specifically human moral experience. An example is C. S. Lewis's argument (in *Mere Christianity*) based on the fact of quarrels and the moral law these presuppose (otherwise, people would not make excuses for breaking the moral law): (1) moral obligation exists within every person; (2)

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[20] Ibid., 36.

[21] *Collins English Dictionary*. (Glasgow: Harper Collins, 1991).

[22] Allison, *The Baker Compact Dictionary of Theological Terms,* 51.

a sense of obligation can come only from one to whom moral authority is rightly ascribed; therefore, (3) this obligation must come from a moral lawgiver, who is God. See also a posteriori/a priori; cosmological arguments; God; knowability; ontological arguments; teleological arguments.[23]

Moral Distress:

"Moral distress was originally defined as occurring when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."[24]

Moral Resilience:

"Moral resilience has been defined as "the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks."[25]

Nurse:

A nurse who has graduated from a course in nursing and is licensed to practice the profession.[26]

Limitations

The research for this paper is limited geographically to the Capital District of New York State. Barna Group research places the Capital District of New York as being the third most post-Christian area of the United States.[27] A post-Christian culture will probably limit religiosity and a solid understanding of biblical principles with the nurses participating in this research.

Ellis Medicine is a secular hospital. There are Roman Catholic hospitals in the Capital District that include Christian principles as part of their mission, vision, and values, but Ellis

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[23] Ibid., 98.

[24] A. Jameton, *Nursing Practice: The Ethical Issues*, (Englewood Cliffs, NJ: Prentice-Hall, 1984:6).

[25] C. H. Rushton, J. Batcheller, & K. Schroeder, "Burnout and resilience among nurses practicing in high-intensity settings," *American Journal of Critical Care,* 24(5) (2015): 412–420.

[26] *Collins English Dictionary*, 1991.

[27] "The Most Post-Christian Cities in America: 2017," Barna Group. Accessed January 25, 2020. https://www.barna.com/research/post-christian-cities-america-2017/.

Medicine does not include any religious doctrine as part of their mission, vision, and values. There is a clear understanding at Ellis Medicine that patient, family, and staff religious beliefs are to be respected but cannot be imposed as part of medical decision making unless requested by the patient or family being treated. A doctor or nurse has a right of refusal to treat based on strongly held religious or moral beliefs, but they are obligated to immediately find another practitioner to provide the treatment.

A majority of nurses are female. There are some male nurses, but the availability of male nurses to participate in this research is limited. According to Montana State University's Center for Interdisciplinary Health Workforce Studies, in 2017 the number of male nurses had remained steady at eleven percent over the previous five years.[28] Extra effort will be made to recruit male nurses to participate in this research.

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Delimitations

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The research for this paper is limited to Ellis Hospital in Schenectady, New York. The researcher has provided chaplaincy services at Ellis Hospital for the past eight years and has observed nurses struggle with frequent moral distress. Delimiting the research to Ellis Hospital creates an opportunity to improve nurse's moral resilience at Ellis Medicine and improve quality of care for patients.

The research for this paper could have been broader and included nurses from other hospitals, but broadening the research to nurses at other hospitals would also broaden influencing factors and limit the opportunity to implement a practical project to promote moral resilience.

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[28] "2017 Data Brief Update: Current Trends of Men in Nursing," Center for Interdisciplinary Health Workforce Studies, Montana State University. Accessed January 25, 2020. http://healthworkforcestudies.com/publications-data/data_brief_update_current_trends_of_ men_in_nursing.html.

Some influencing factors in a broader research scope would include competing cultural norms, secular versus religious hospital settings, and access to nurses at other hospitals.

Thesis Statement

If nurses at Ellis Medicine are educated on how to make ethical, moral, biblical decisions then they will be able to overcome barriers in making these decisions. The basis of developing moral resilience in healthcare is having a solid understanding of core principles in medical ethics that incorporate biblical theology. Habgood offers a good theological reminder that too often, humans try to play God. He makes note that a certain amount of pain and suffering is inevitable in life and that theology plays a critical role in how humans respond and cope with this pain and suffering.[29] There is no place more palpable with pain and suffering than a hospital. Nurses and doctors take on a great amount of stress in their tireless efforts to help people with medical interventions that may lead to a cure. Unfortunately, when a cure is not possible, doctors and nurses feel a sense of failure.

Pellegrino raises the issue of competing forces in today's society that impact a Christian doctor's ability to draw upon their religious beliefs and practices as part of their medical decision making.[30] These same forces have an impact on Christian nurses in their practice. The pressure from these competing forces places another level of strain on a nurse's ability to make good ethical, moral, biblical decisions in their daily practice of caring for the sick and dying. It is important to note, however, that nurses of any religious tradition have an obligation to provide respectful, compassionate, high-quality care to all of their patients without imposing their

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[29] J. S. Habgood, "Medical ethics—a Christian view," *Journal of Medical Ethics*, 11 (1985), 12–13.

[30] Edmund D. Pellegrino, and David C. Thomasma, *Helping and Healing: Religious Commitment in Health Care*, (Washington, D.C.: Georgetown University Press, 1997).

religious beliefs on a patient or family in their professional setting. There are provisions for

medical providers to implore a moral objection to provide an intervention that is contrary to their

strongly held moral or religious beliefs. "Physicians are not legally required to honor a treatment

decision that contravenes their religious, moral, or professional convictions."[31]

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[31] Karl Adler, "When Others Must Choose: Deciding for Patients Without Capacity." New York State Task Force on Life and Law, 1992. file:///C:/Users/revto/Documents/when_others_must_ choose.pdf, 187.

Chapter 2

Conceptual Framework

The literature review for this paper draws upon the insights of scholars who have written on ethics and moral distress in nursing within the healthcare system. Scholars have published a great amount of research since the 1980s, when Jameton first recognized moral distress in nursing. The literature review for this paper has been done through the lens of action research.

Medical ethics and moral distress are tied together. Nurses often face moral and ethical problems when they are providing care to their patients. The research shows there are many barriers that prevent nurses from making good ethical, moral, biblical decisions. When nurses are unable to make good ethical, moral, biblical decisions, they experience moral distress. Moral distress in nursing then leads to quality-of-care issues, stress, and burnout in the nursing profession, along with a hostile work environment.

Chaplains are particularly and professionally suited to help alleviate the barriers for nurses and help them grow in their ability to make good ethical, moral, biblical decisions. Since chaplains and nurses work very closely in providing patient care, and since religion and spirituality play a big part of good ethical, moral, biblical decision making, chaplains can take the lead in providing education and resources for nursing staff on the issues of ethics and moral distress.

Literature Review

There is a strong consensus throughout the literature that ethical decision making in medical practice initially comes from an emotional response. Habgood notes that medical professionals suffer a great burden in making life-and-death decisions as they care for people.[32]

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[32] Habgood, *Medical Ethics – a Christian View,* 12–13.

As the coronavirus pandemic came to be, the burden of making life-and-death decisions grew exponentially for physicians and nurses. The burden grew because the medical system in many areas of the world became overwhelmed with the number of people that needed critical care to save their lives. Additionally, doctors, nurses, and other care professionals had the added burden of fear that they might become infected with the coronavirus themselves.

One of the greatest issues that doctors and nurses have faced is the shortage of life-saving medical supplies and equipment. Most state health departments have some guiding documents on file related to the rationing of medical resources. In many cases, these guidelines were not produced in anticipation of the scale and magnitude of a shortage.

> The coronavirus disease 2019 (COVID-19) outbreak raises unique ethical dilemmas because it makes demands on society from all sectors of life, nationally and across the globe. Health professionals must deal with decisions about the allocation of scarce resources that can eventually cause moral distress and may affect one's mental health.[33]

The Hastings Institute developed an ethical framework for healthcare institutions. Many hospitals have used this framework, alongside the directives of their department of health guidelines, to create policy on allocation of scarce resources.[34] The Hastings Institute framework helps to ensure physicians and nurses make the best ethical decisions possible when there is a critical shortage of resources, but even with the best framework, physicians and nurses will still experience moral distress because they are prevented from providing life-saving care that they would otherwise be able to provide.

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[33] Erwin J. Khoo, and John D. Lantos, "Lessons Learned from the COVID-19 Pandemic," *Acta Paediatrica*, 2020, 2.

[34] "Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic," The Hastings Center, accessed May 2, 2020, https://www.thehastingscenter.org/ethicalframeworkcovid19/.

Maciejewski says that disengagement is a coping strategy to avoid an emotional

reaction.[35] Disengagement may temporarily alleviate emotional and spiritual pain on the part of

the medical professional, but the disengagement will eventually wear thin and will not be an

available coping mechanism. Disengagement will, clearly, have an impact on a patient's

perception of the lack of compassion or empathy a medical professional has. Duarte et al. say,

> Nurses face the challenge of finding the balance that allows them to resonate with patients' suffering without becoming emotionally over-involved in a way that might lead to burnout and compassion fatigue. This study's findings suggest that teaching self-compassion and self-care skills (i.e., a tendency to be kind and understanding towards oneself, to feel interconnected with other people and to hold negative experiences with mindful awareness), may be an important feature in nursing educational interventions that aim to reduce burnout and compassion fatigue.[36]

Hojat distinguishes between sympathy and empathy.[37] She notes that cognition is engaged in the

medical professional when they empathize with a patient, whereas emotion is engaged when the

medical professional sympathizes with a patient. A major component of empathy in the

healthcare arena is the ability to communicate understanding and to ensure there is mutuality

with the patient. If a healthcare professional sympathizes with their patients day after day, they

will deplete their feelings and put themselves at risk of compassion fatigue or burnout.

On the other hand, medical professionals cannot completely emotionally disengage.

Pellegrino says the Christian principle of justice in healthcare is wedded to benevolence and

beneficence.[38] If nurses and doctors are emotionally disengaging from patients and families, they

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[35] Paul K. Maciejewski et al., "Religious Coping and Behavioral Disengagement: Opposing Influences on Advance Care Planning and Receipt of Intensive Care Near Death," *Psycho-Oncology,* 21(7), (July 2012), 714–723.

[36] Joana Duarte, José Pinto-Gouveia, and Bárbara Cruz, "Relationships between Nurses' Empathy, Self-Compassion and Dimensions of Professional Quality of Life: A Cross-Sectional Study," *International Journal of Nursing Studies,* 60 (2016), 11.

[37] Mohammadreza Hojat, *Empathy in Health Professions Education and Patient Care*, (Place of publication not identified: Springer, 2018), 77.

[38] Edmund D. Pellegrino, and David C. Thomasma. *Helping and Healing*

are at risk of denying the patients and families justice—the best healthcare possible. At their

core, benevolence and beneficence involve an element of emotion and spiritual engagement.

Benevolence and beneficence involve a certain amount of empathy. Christians are very aware of

the empathy Jesus demonstrated in his earthly ministry. A great example is Jesus' healing of

Simon Peter's mother-in-law (Luke 4:38–40).[39] It is important for nurses to know that they may

not be able to cure the physical dis-ease of their patients, but they can represent the healing

ministry of Jesus in their practice of medicine.

The United States has many religious beliefs, philosophical differences, and a strong push

toward individuality. A recent Pew Research poll indicates there is a widening gap in those who

think it is necessary to believe in God to make good moral choices and those who do not.[40] As

the older nurses retire out and younger nurses come in, the healthcare system is likely to see

more nurses that fit into the category of feeling they do not need to believe in God in order to

make good ethical and moral decisions. Davis et al. in their study on influencers of ethical beliefs

and their impact on moral distress and conscientious objection found that one-third of the cohort

stated their work and/or life experience had the most influence on their ethical beliefs. Religious

beliefs counted for almost another third in the study. The study makes it clear that religious

beliefs remain an important factor in ethical decision making.[41] It will be up to chaplains and

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[39] All biblical references are from the *American Standard Version* unless otherwise noted.

[40] Gregory A. Smith, "Do You Have to Believe in God to Be Moral? Most in US Say No," Pew Research Center, last modified October 16, 2017. https://www. pewresearch.org/fact-tank/2017/10/16/a-growing-share-of-americans-say-its-not-necessary-to-believe-in-god-to-be-moral/.

[41] Shoni Davis, Vivian Schrader, and Marcia J Belcheir,*" Influencers of Ethical Beliefs and the Impact on Moral Distress and Conscientious Objection,"* Nursing Ethics, Vol. 19 (2012).

religious leaders to ensure religious beliefs remain important to medical professionals in their work and daily life.

Puteri et al. discuss how religion and spirituality are important to a person's sense of security and belonging.[42] While Puteri et al. point to the differences between religion and spirituality, it is clear the two go hand in hand.[43] The opportunity Christians have is to talk about faith, tradition, and beliefs with the new, young, and possibly non-religious nurses and other medical providers. In doing so, these medical professionals may gain a better understanding of good ethical, moral, biblical decision making, and potentially absorb such an understanding as their own. However, Christians must be cautious to give all due respect to the basic freedom of religion and welcome divergent viewpoints, while remaining committed to the Christian religion.

Sheep notes that most world religions have dogma on the sacred aspect of work—what we Christians may call *vocation*.[44] The literature supports a strong feeling of the sacred in the work of nursing; religion and spirituality are discussed in all the literature on medical ethics and moral distress. Sheep references Henry Ford's quote, "Why is it that I always get the whole person when all I really want is a pair of hands?"[45] Medical institutions have embraced hook, line, and sinker the many business models for increasing productivity in medical care. This literature review is focused on nursing, but an important component is the ethical responsibility

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[42] Puteri Nemie Jahn Kassim, and Fadhlina Alias, "Religious, Ethical and Legal Considerations in End-of-Life Issues: Fundamental Requisites for Medical Decision Making," *Journal of Religion and Health* 55, no. 1 (October 2015), 119–34.

[43] Ibid.

[44] Mathew L. Sheep, "Nurturing the Whole Person: The Ethics of Workplace Spirituality in a Society of Organizations," *Journal of Business Ethics*, 66 (2006), 357-375.

[45] Ibid., 358.

of healthcare organizations, especially hospitals.[46] Healthcare is missing the mark when it draws so heavily on business models.

Lee notes the healthcare profession has gotten lost in the financial gain of the care they provide and, as a result, is lacking the empathy that patients want.[47] While Lee does not write from a Christian perspective, his thesis is very relevant and important to the problem at hand. The financial incentives that doctors receive for their so-called productivity has taken away much needed finances to support nursing staff. Haddad notes that upwards of one million additional nurses would be needed in 2020.[48] The nursing shortage is putting an additional strain on nursing practice. The shortage of nurses is all the more reason to provide high-quality chaplain services to support and educate nurses on how to address ethical and moral issues from a biblical perspective. Otherwise, those in need of medical services will find themselves in a hospital with burned-out nurses in a hostile work environment, which will have a negative impact on the care they receive.

Habgood says, "The real resources of theology lie not in some intellectual scheme, but in the awareness of a power greater than our power, a care for individuals greater than our own capacity for failure and error, which makes it possible for us to live with ourselves without complacency and without despair."[49] If nurses and other medical providers can draw upon an ethic that realizes a power greater than their own power, they will be able to make good ethical,

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[46] Ibid.

[47] Thomas H. Lee, *An Epidemic of Empathy in Healthcare: How to Deliver Compassionate, Connected Patient Care That Creates a Competitive Advantage*, (New York: McGraw-Hill, 2016).

[48] Lisa M. Haddad, "Nursing Shortage," StatPearls [Internet], last modified November 12, 2019. https://www.ncbi.nlm.nih.gov/books/NBK493175/.

[49] Habgood, *Medical Ethics—a Christian View,* 13.

moral, biblical decisions that bring peace, empathy, and comfort to the patients and families they care for.

Theological Foundations

The prophets in the Old Testament offer a great amount of insight about God's healing power. A reader will notice that most of the healing referenced in the prophets is related to the whole community rather than an individual person. Isaiah 53:4–5 prophecies that the Messiah, Jesus, takes on humanity's pain and suffering, and does so on behalf of humanity because of transgressions; Isaiah says God's people are healed because of Jesus' wounds. Jeremiah 30:17 says the Lord will restore health and heal wounds. Isaiah 57:18–19 demonstrates the compassion of the Lord: "I have seen their ways, but I will heal them; I will guide them and restore comfort to Israel's mourners, creating praise on their lips. Peace, peace, to those far and near," says the Lord. "And I will heal them." Psalm 30:2 says, "Lord my God, I called on you for help and you healed me."

Throughout the Old Testament of the Bible, there are prophecies and sacred stories of God's power to strike down and to heal, but it was through the birth, ministry, death, and resurrection of God's only son, Jesus Christ, that God's reconciliation and complete healing of humanity came to fulfillment for all the people of the world.

The gospels of the New Testament provide the best account of God's concern for each one of God's children, as a community and individually. Jesus' life, ministry, death, and resurrection brings the kingdom of God close at hand, and much of that closeness has to do with his healing. This paper will draw heavily on the healing ministry of Jesus as presented by the gospel writers. Jesus' ministry of healing during his time on earth reflects upon and influences the healing ministries of today. All Christians are called on to model Jesus and his ministry. If

compassion and healing were at the core of Jesus' ministry, then compassion and healing must be at the core of any ministry today and in the days ahead.

According to most scholars, the earliest gospel is the Gospel of Mark. Scholars believe that Mark was written sometime around 60 A.D. This earliest writing about Jesus' life and ministry has a key theme of Jesus' suffering and how Jesus' disciples are to follow him in the same way (Matthew 8:34–10:52). The Oxford Bible Commentary notes,

> Jesus is also the great miracle worker, though one suspects that Mark would not see this as the most important part of Jesus' ministry. Jesus is indeed the great miracle worker, but miracles must, for Mark, be seen in their proper context; they can never be the basis for faith, indeed without an existing context of faith, they cannot take place (see 6:5); further, the one who performs all these mighty works is the one who will end up on the cross.[50]

Although Mark may be mostly focused on the suffering of Jesus, early in Mark's gospel he writes about Jesus healing a man with an unclean spirit immediately after the calling of the first disciples (Mark 1:21–28). Jesus then goes to the home of Simon Peter where he heals Simon's mother-in-law, and later that evening heals many who had heard about him (Mark 1:29–34). The commentaries indicate these healings are to demonstrate the authority of Jesus more than to show the healing power and nature of Jesus. This may be the case, but to demonstrate authority through the power of healing indicates that healing is very significant to Jesus and his ministry.

Turning to the Gospel of Matthew, there is also a great amount of healing in Jesus' ministry. According to some scholars, Matthew wrote around 70 A.D., when there had been a revolt and the Pharisees dominated. The Pharisees focused on keeping the Jewish community unified and differentiating the Jewish community from various religious movements in society at the time, including Christianity. Matthew's gospel has a focus on uniting Christians. The Sermon

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[50] John Barton and John Muddiman, *Oxford Bible Commentary*, Oxford: Oxford University Press, 2001: 887.

on the Mount may be seen as Jesus' greatest discourse and provides the Christian community with an imperative teaching on living for the kingdom of God.

Immediately before Jesus' Sermon on the Mount discourse, Matthew says that Jesus traveled throughout Galilee, teaching in the synagogues and proclaiming the good news of the Kingdom of God. Matthew goes on to say Jesus was curing every sickness and disease among the people; his fame spread, so the people brought many who were sick to him, and he cured them (Matthew 4:23–25). It was during this episode of the crowds going to Jesus that he went up the mountain and sat down to teach them. Following the Sermon on the Mount, as Jesus was coming down the mountain, a leper came to him and kneeled before him with a request for healing. Jesus did not hesitate; he healed the leper.

It is significant that Jesus healed people immediately before and after the Sermon on the Mount. The Sermon on the Mount stands between the two healings to demonstrate what is required of one who experiences the healing power of God. Culpepper says,

> The first healing story, following the Sermon on the Mount, demonstrates not only Jesus' power in word and deed, but also illustrates the nature of the purity required of Jesus' followers. In the beatitudes, Jesus declared, 'Blessed are the pure in heart, for they will see God' (5:8; cf. Ps 24:3–4). Purity rituals were exceedingly important among Jews in the Second Temple period—perhaps as an effort to maintain identity and reinforce boundaries in response to the cultural upheaval brought about by Hellenization and Romanization, oppression, and the introduction of foreign religious cults during this era. Miqva'ot (ritual baths) and stone vessels (that resisted impurity) were common in Galilee as well as in Jerusalem. Issues of purity divided Jews (e.g., Pharisees and Essenes) and were maintained not only by priests, but also by many laity (Harrington 2010:1121). In this highly charged context, Jesus illustrates the coming of the Kingdom and its transformation of ritual purity into ethical purity of heart (Viljoen 2014a:6).[51]

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[51] Richard A. Culpepper, "Jesus as Healer in the Gospel of Matthew, Part II: Jesus as Healer in Matthew 8–9." *In Die Skriflig/In Luce Verbi* 50, no. 1 (2016): 3.

The ethical purity of heart, based on the Sermon on the Mount, demonstrates what a nurse, and all medical providers, including chaplains, are to embrace to put Jesus' ethical teaching into action as they engage in the act of a healing ministry on behalf of our Lord. Harkness says,

> So universal is Jesus that while everybody knows he was a Jew, this is not what we ordinarily think about when we look to him for moral guidance. The Sermon on the Mount is for the twentieth-century American as much as it was for the first-century Jew, and requires only a little transference out of its Palestinian context in order to "speak to our condition." This is not to say there are no problems in it. Yet its universal affirmations and imperatives so far transcend its problems that for centuries hosts of Christians, most of them not theologians or professional moralists, have been guided and nourished by it.[52]

A true healing ministry involves both science and religion. Science and religion are not opposed to one another. Science is woven into Christian bioethics as much as it is secular bioethics. Scientists continue to grow in and gain knowledge about the biology and physiology of the human body. It is the duty of pastors, theologians, and chaplains to keep moral duty as part of the ethical discussion as growth and gain in scientific ability continues. The plethora of information on scientific advancement can easily distract us from the importance of spirituality and faith.

Dobson notes that we now live in an age of distraction, which changes how we mourn and how we cope with sorrow. Dobson says,

> A constant flow of tragic knowledge overwhelms us, triggering everything from outrage to resignation. In 2018, almost 70 percent of Americans reported feeling "news fatigue." We simply aren't made to handle the scope and depth of suffering in the world, so we turned off our TVs. But the news kept coming via Facebook, Twitter, and Instagram, outlets through which we can instantly express our sorrow. The age of distraction is changing how we grieve. Yet Jesus' timeless Beatitude promises comfort: "Blessed are those who mourn, for they shall be comforted" (Matthew 5:4). How do we mourn in an age of distraction?[53]

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[52] Georgia Harkness. *Christian Ethics: Emerging Social Trends and the Future of American Christianity*. Nashville, TN.: Abingdon Press, 1952, ch.3.

[53] Jonathan K. Dobson, *Our Good Crisis: Overcoming Moral Chaos with the Beatitudes*, (Downers Grove, IL: IVP, an imprint of InterVarsity Press, 2020), 41–42.

Dobson raises a good question. How do we mourn in an age of distraction? While Dobson's focus is on the worldly distractions, in the context of this thesis we may consider the distractions that patients, families, physicians, and nurses experience while experiencing sorrow and mourning the loss of normalcy due to a health crisis. Anyone who accesses or is professionally involved in the healthcare system can quickly become overwhelmed with the amount of information that is thrown at them. Patients and families are overwhelmed with medical information that is difficult to interpret to make a good decision. Physicians and nurses are overwhelmed with information on new diagnostics, treatments, and available medications. Being overwhelmed with information distracts from being able to mourn and acknowledge the sorrow of life change and loss.

Dobson suggests that even if people do not become overwhelmed with information as a distraction, there is some natural instinct to create a distraction.

> Why do we minimize and maximize our sorrow? On the surface, it seems to be a very unhealthy thing to do. We dismiss or expand our sorrows because, deep down, we're unsure what to do with them. While expressing our emotions is certainly a way we deal with disappointment, it's not enough. Emotions alone do not have the ability to resolve things. An important question lurks behind our emotions: Why? Why did this happen? In the words of Nietzsche, "A man can endure almost any how if only he has a why."[54]

When people experience a loss of any kind, they ask why such a thing happened to them. In a health crisis, why-questions are front and center. Physicians and nurses are able to go only so far until they run out of answers. It is at this point that chaplains are often brought in to address the why-questions from a theological perspective. Chaplains do not necessarily have answers for the why-questions, but they can point to God's loving presence. Chaplains may point to Jesus' beatitude in Matthew 5:4 as assurance that they will be comforted.

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[54] Dobson, *Our Good Crisis: Overcoming Moral Chaos with the Beatitudes*, 43–44.

Matthew goes on to walk his readers through other healings by Jesus: healing many at Peter's house, the Gadarene demoniacs, and the paralytic. Immediately following those healings, Jesus calls Matthew to follow him. Jesus went to Matthew's house and, during dinner, the Pharisees questioned why a teacher would break bread with sinners. To this Jesus said, "Those who are well do not have need of a physician, but those who are sick do" (Matthew 9:9–12).

In the midst of healing, and at times being crushed by the demands of the crowds, Jesus had to take leave for his own self-care through rest, prayer, and reflection. Nurses, and all medical professionals, also need to take time for self-care in order to do the good work of healing. Jesus leaned on and called on God to help him along the way in his ministry. Nurses benefit when they take time to call on Jesus, the Son of God, along the way in their ministry of healing. Even if a nurse does not identify as a Christian, they can benefit from the sacredness of Jesus' message through holy scripture.

Jesus, as the new covenant of God, has reconciled the world through his blood. "This cup is the new covenant in my blood" (1 Corinthians 11:25). God's covenant promise of reconciling the world through the sacrifice of the body and blood of Jesus is important to the theological discussion of ethical decision making. "For God so loved the world that he gave his only begotten son, that whoever believes in him shall not perish, but have eternal life" (John 3:16). As participants in the new covenant, we too are called to love the world. Love is central to ethical decision making in Christian bioethics.

> Love does not always "work" in the sense of securing the desired results. Yet without it, nothing else is more than a temporary palliative for the checking of evil. Giant structures of power in conflict with one another breed other conflicts, until man's status upon earth grows more and more precarious. Justice we must have, but justice directed by good will and concern for persons. The only effective road to a good society was described centuries ago in the words, "Do not be overcome by evil, but overcome evil with good."

> If an earnest effort is made in faith and devotion to follow this route, God can be trusted to give us light and direction along the way.[55]

Hershberger makes an excellent point about the blend of science, religion, and the loving, abiding mystery of faith. Hershberger discusses her time as a missionary nurse.[56] She notes how important it is for those in a healing ministry to pause and reflect on their own biases. Hershberger encountered a missionary friend in Africa who told her how African's blend Western medicine with their own worldview—a deeply spiritual, transcendent, and immanent worldview. The friend said the Africans were very glad to learn from the Western medical people about the parasites that cause malaria, but they had a question. What causes the mosquito carrying that malaria to bite one person and not the other? The point is that all things cannot be explained by modern medicine; some things continue to be theological and under the control of the mystery of God.

Finally, Hershberger makes a very strong theological point that impacts the research at hand. She quotes Philippians 2:4–8:

> Let each of you look not to your own interests, but to the interests of others. Let the same mind be in you that was in Christ Jesus, who, though he was in the form of God, did not regard equality with God as something to be exploited, but emptied himself, taking the form of a slave…he humbled himself and became obedient to the point of death—even death on a cross.

Theoretical Foundations

Following a symposium on transforming moral distress into moral resilience in nursing in 2016, the American Association of Nursing published a paper titled, "A Call to Action:

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[55] Georgia Harkness. *Christian Ethics: Emerging Social Trends and the Future of American Christianity*, ch.6

[56] Ann Graber Hershberger, "Missionary Nursing," *Journal of Christian Nursing,* 21, no. 1 (2004), 4–9.

Exploring Moral Resilience Toward a Culture of Ethical Practice." in 2017.[57] Rushton and

Sharma, authoring the paper, build on the theory that development of moral resilience in nursing

is promising for mitigating the moral distress and suffering that nurses encounter in their work

environment. Rushton and Sharma offer four areas for building moral resilience capacity in

nursing: ethical competence, ethics in education, self-regulation and mindfulness, and self-care.

In the area of education, Rushton and Sharma suggest development of teachable skills as

part of nursing education that will lead to ethical competence in nursing. They note, "Ethical

decision-making theories include practice and change theory, conflict management, and moral

development theory."[58] Throughout the United States, someone can become a registered nurse

with an associate degree in nursing. However, many—if not most—states are moving toward

amending the education requirements to a bachelor's degree requirement in order to become a

registered nurse. Increasing the nursing degree requirement seems like a good move considering

the ever-increasing complexity of medicine and the complicated psychosocial dynamics that

nurses are faced with on a daily basis.

Rushton and Sharma suggest nursing education programs build in teaching on

mindfulness, spiritual well-being, self-regulation, and self-reflection as part of the curriculum for

registered nurses.[59] They cite ample research that mindfulness if the best intervention to reduce

stress and emotional exhaustion. The research also indicates mindfulness helps strengthen the

development of mental flexibility.[60]

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[57] Cynda Hylton Rushton, and Monica Sharma, "Creating a Culture of Moral Resilience and Ethical Practice," *Oxford Medicine Online*, 2018.

[58] Ibid., 7.

[59] Ibid.

[60] Ibid.

The Code of Ethics for Nurses states that nurses owe the same duties to self as they owe to others.[61] This is a difficult requirement for nurses, and anecdotal evidence suggests that nurses are under such a great amount of pressure to take care of their patients that they often do not take care of themselves. On the surface, this may appear a very good thing for patients, but it is well known that an unhealthy caregiver is ill-prepared to take care of others. Therefore, not only does the nurse suffer; the patient also suffers from lack of the best quality of care.

> Intentionally fostering interventions aimed at supporting physical, emotional, spiritual, and social well-being supports nurses faced with moral adversity. When nurses are imbalanced or depleted in any aspect of their being, they are more vulnerable to the negative effects of moral adversity or moral distress.[62]

If nursing schools begin to add ethics and moral resilience classes as part of a four-year degree requirement for registered nurses, and healthcare organizations begin to include such skills as part of competency requirements, nurses will gain moral resilience and patients will receive better nursing care.

Pavlish and Brown-Saltzman did a research study to explore nurse leader experiences of working in ethically difficult situations and how they were able to help nurses cope with moral distress.[63] Multiple factors in the study of 100 nurse leaders proved that moral distress is a dominant issue that needs to be addressed in the field of nursing. The authors of the study developed a model called SUPPORT as a result of their research. The model appears well crafted and may be useful, but the researchers did not continue the research to determine if the

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[61] Ibid.

[62] Ibid.

[63] Carol Pavlish, and Katherine Brown-Saltzman, *The Journal of Nursing Administration*, vol. 46, no. 6 (June, 2016): 313–320.

SUPPORT model is effective in tempering moral distress and increasing moral resilience.

Figure 1: SUPPORT Model

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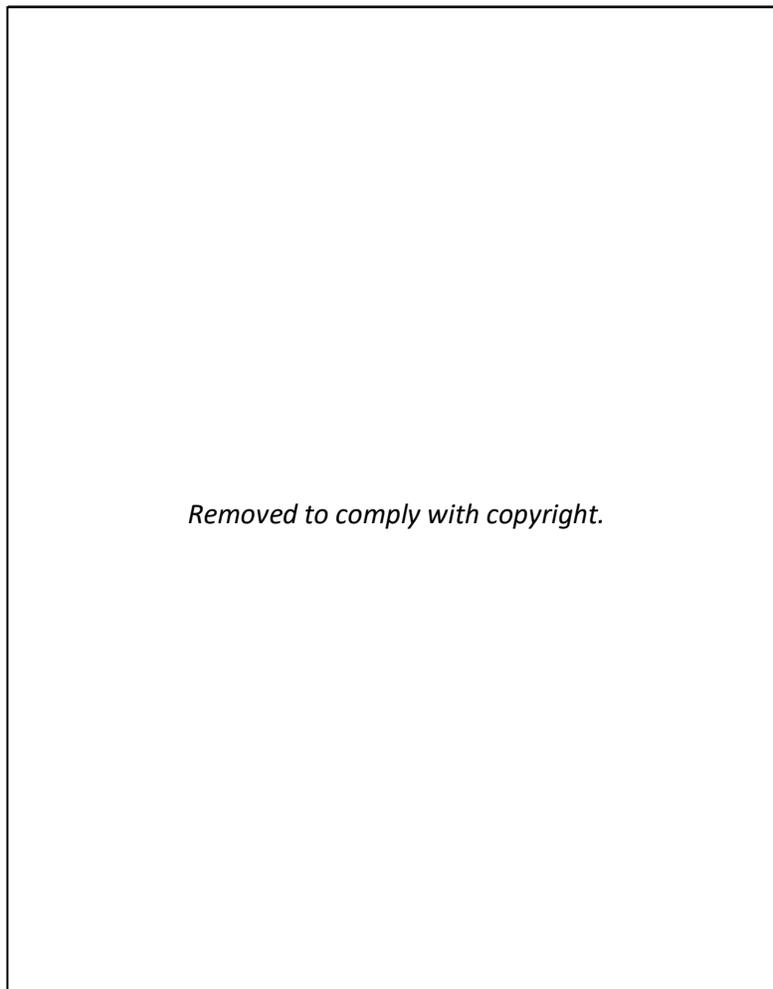
[64]

This researcher theorizes that O'Brien's model of sacred covenant paired with Pavlish and Brown-Saltzman's model of SUPPORT will provide a foundation for development of an education program that will improve Ellis nurses' ability to overcome barriers and gain new skills to address ethical dilemmas that create moral distress in their practice of nursing. O'Brien's model focuses on service, empathy, agape love, empowerment, and the nurse-patient relationship, all emerging from a spiritual and theological perspective. Pavlish and Brown-Saltzman's model focuses on relationship, environment, clinical decision making, policy making,

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[64] Pavlish and Brown-Saltzman, *The Journal of Nursing Administration*, 318.

and the nursing code of ethics. Integrating these two models and developing an education

program to hard-wire the determined methods into nurses' everyday practice should ultimately

result in less moral distress and more moral resilience.

Chapter 3

Methodology

The research for this project began after the Internal Review Boards at Liberty University and Ellis Medicine gave approval for the research project. See Appendix A for IRB approvals. The researcher acknowledges his unconscious bias as an employee of Ellis Medicine and a chaplain who works with nurses at Ellis Medicine every day. The researcher entered into the research realizing he may project some perceptions or foreknowledge onto the data he would gather.

The methodology used in this research to address the problem of nurses at Ellis Medicine facing barriers in making good ethical, moral, biblical decisions was qualitative, interpretive, and longitudinal. The qualitative research was done through interviews with five participant nurses. The interpretive method was followed during the interviews, and when analyzing transcripts and surveys following the interviews. The researcher also used explorative and descriptive practices in gathering information for the research participants. This research project was done over a period of twelve weeks.

The researcher spoke with a director of nursing for Ellis Hospital, who is also an instructor at the Ellis Belanger School of Nursing, regarding the education nurses receive on ethics in healthcare during nursing school and when they are hired at Ellis Hospital. The nursing director stated there is no ethics in healthcare class at Belanger School of Nursing and there is no education on ethics or moral distress as part of the new nurse orientation at Ellis Hospital. The director stated she feels this is a gap in nurses' education and training. The Nursing Education Department at Ellis Medicine does incorporate some ethics education through an online platform called HealthStream. Also, all members of the Institutional Review Board are required to

complete the CITI Training for IRB Board Members, and members of the Ethics Committee are given educational packets as part of their orientation to the committee.

The researcher has been the chairman of the Ethics Committee at Ellis Medicine for the past five years. Many of the ethics consult requests sent for an ethics review may have been solved at the nursing level if the nurses were better educated and skilled in addressing ethical and moral dilemmas that arise in their everyday work. The literature review supports that this is not a problem unique to Ellis Medicine. There is a particular gap with regard to understanding the basic bioethical principles and theological issues and implications that may be present in ethical dilemmas.

As noted in the literature review, the Capital Region of New York is one of the least religious areas of the United States. Additionally, Ellis Medicine is a secular hospital and does not subscribe to any particular religious foundation as part of its mission. However, pastoral care and religious beliefs of patients, their family members, and staff are all held in a high regard and given due consideration at Ellis Medicine. Even so, theological reflection often takes a back seat to law, regulation, and policy in the process of ethical deliberations.

Intervention Design

This researcher discussed the research problem and the planned intervention with key stakeholders at Ellis Hospital. The key stakeholders included the directors of nursing, and managers of the intensive care unit and Emergency Department. After getting buy-in from those key stakeholders and approval from the Liberty University and Ellis Medicine Internal Review Boards, the research began with the researcher visiting nurses one on one in the intensive care unit and the Emergency Department at Ellis Medicine to recruit participants. The recruitment effort took place over a two-week period. Beside one-on-one discussions, recruitment efforts also included an email to all nurses in the ED and the ICU, along with posting a flyer on the bulletin

boards in those areas. During the recruitment process, twelve nurses expressed interest and stated they felt the research topic was very important to their practice. Seven of those nurses did not answer emails, return calls, or follow through in any way on signing up to participate in the research project; the research proceeded with five nurses committed to full participation in the research project.

The original design was to conduct an initial focus group with participant nurses. Within four weeks after the initial focus group, the researcher would provide education to participant nurses on ethical, moral, biblical decision making in the healthcare setting. Finally, in another four weeks, the researcher would conduct a final focus group with nurse participants to evaluate if they felt increased ability to make better ethical, moral, biblical decisions in their nursing practice, if they had a better understanding of moral distress and moral resilience, and if they had gained ability to lessen moral distress and grow in moral resilience.

When this project began, the coronavirus, COVID-19, emerged—which became a barrier to recruitment and moving forward with the research. Nurses were working longer hours, in-person meetings were suspended to mitigate exposure and spread of coronavirus, and it was difficult for nurses to give attention to anything other than preparing and caring for the many people who were showing up at the hospital with coronavirus. In many ways, the emergence of coronavirus proved the high impact of moral distress on the everyday life of a professional nurse. Moral distress was very apparent as nurses began to express helplessness, anxiety, fear, frustration, and anger—a few of the symptoms of moral distress. However, there was also anecdotal evidence of nurses' moral resilience as they banded together and supported one another through the difficult first weeks of the coronavirus pandemic.

The research design was adjusted slightly to meet the stringent guidelines implemented by Ellis Medicine to mitigate the spread of coronavirus. Instead of an initial focus group for the interviews, the research began with an interview with each nurse participant. The researcher initially planned to allow four weeks between focus groups and education, but with fewer nurse participants, the research moved along at a pace of two weeks between the interview, education, and survey.

The interviews were scheduled with each nurse over a period of two weeks. Two weeks following the interviews, the researcher met with each nurse and provided an education session on ethics, moral distress, and moral resilience. The education sessions took place over a period of two weeks. Immediately after the education sessions, the nurse participants completed a survey with eight questions to evaluate the impact of their education session with the researcher.

This research project was designed to give participant nurses an opportunity to speak and be heard about their experiences with ethical dilemmas, moral distress, and what they feel are barriers to making good ethical, moral, biblical decisions in the nursing practice. The initial interview provided such an opportunity for the participant nurses, and they were very forthcoming in sharing first-hand accounts of situations involving ethical dilemmas that created moral distress in their nursing practice. It was evident in the interviews that nurses with more experience are better equipped through that experience to handle moral dilemmas and possess more skills to break through barriers to maintain moral resilience.

Implementation of Intervention Design

The researcher planned to recruit fifteen to twenty nurses to participate in this study. At the same time that the researcher was ready to recruit, hospital systems went into overdrive in preparing for and responding to the coronavirus pandemic. The administration at Ellis Hospital

put plans in place for doctors, nurses, and other essential medical personnel to stay overnight at the hospital to ensure adequate staffing. The Human Resources and Pastoral Care Departments collaborated in providing interventions and opportunities for stress reduction and spiritual guidance.

The chaotic transition to a new normal for hospital operations lasted several weeks. As soon as the researcher observed the organizational stress level due to coronavirus had subsided at Ellis Hospital, recruitment efforts began. Nurses continued to experience great stress as they provided for the needs of their patients, but they slowly appeared to be more available to have a conversation about this research project.

The researcher went to the intensive care unit and the Emergency Department every other day for one week and spoke with nurses one on one regarding this research project. The response varied between nurses who said they were very interested in the project but simply did not have the time to participate, nurses who said they were interested and took the contact information for the researcher, and those who were very interested and shared their own contact information so the researcher could follow up with them to participate when the research actually began.

Twelve nurses were recruited through in-person contact and agreed to participate in the research—six from the ICU and six from the ED. The researcher reached out to all twelve of the nurses by email and phone calls to schedule the initial interviews. Five nurses did not respond to emails or phone calls. Two nurses that responded to an email from the researcher agreed to participate and schedule an initial interview, but then later decided they could not devote the time required to participate. Five nurses participated in the study from beginning to end—three from the ICU and two from the ED.

The researcher provided the five participant nurses with a copy of the informed consent to review by email. The email included basic information about the study structure and time commitment. All five nurses responded, acknowledged receipt of the informed consent, and indicated they were looking forward to participation.

The interviews with participant nurses were scheduled for one hour. One interview was completed in person in the ICU, and four interviews were completed by phone. One phone interview was conducted with two nurses at the same time.

The initial interviews were focused on assessing the participating nurses' level of knowledge and their experiences of making ethical, moral, biblical decisions in their nursing practice. The nurses were asked about their knowledge of moral distress and moral resilience. Participating nurses were given an opportunity to speak about specific experiences they have had with ethical dilemmas and moral distress.

The interviews began with the researcher introducing himself, reviewing the purpose of the research, the time commitment for the nurse participants, the planned intervention, and the anticipated outcome. The researcher informed the participants the interview would be audio-recorded, that the recordings would be transcribed without the participants' names, and no one would be identified by name in writings generated from the research.

The researcher asked the following twelve open-ended questions during the interviews with participant nurses:

1. Please tell me your credentials, the area of the hospital where you work, how long you have been a nurse, and what religious tradition, if any, you are now or have ever been personally involved with.

2. How would you define ethics in healthcare?

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3. Describe a time when you identified an ethical dilemma in your nursing practice and what you did about it.

4. How do your religious beliefs play a part in making good ethical, moral decisions as part of your nursing practice?

5. How might the religious beliefs of a patient or family impact your response to an ethical dilemma?

6. What education have you received on ethics in healthcare as part of your formal and informal training?

7. What is your impression of how Ellis Medicine, as an organization, educates and supports nurses in ethical decision making?

8. What are some of the barriers to nurses making good ethical decisions at Ellis Medicine?

9. Describe what Ellis Medicine could do to help nurses feel more confident in addressing ethical dilemmas in nursing care.

10. How would you define moral distress?

11. Describe a time when you felt morally distressed in your nursing practice.

12. What resources do you have to help you when you feel moral distress?

Following the interviews, the researcher evaluated and interpreted the qualitative data gathered for common themes and compared it to the research from the literature review. The researcher found this research does indicate a need for basic education with nurses on the principles of ethics in healthcare, a need for education on the commonly held beliefs in Christianity, as well as other religions, and a need for resources to address moral distress when nurses are confronted with barriers in making good ethical decisions in their nursing practice.

The following is an outline of an intervention strategy this researcher used based on the outcome of the interviews. The primary goal was to improve nurses' practice through education and understanding of ethical dilemmas, while also providing resources to decrease moral distress and increase moral resilience.

The researcher contacted each participant and scheduled one-hour education and training sessions on making good ethical, moral, biblical decisions, and how that can translate into increased moral resilience. The education and training for this research project was structured to be interactive. Based on the interviews, the researcher determined the nurses needed education on the basics in bioethical, theological, and nursing code of ethics. The research also indicated a need for a tool to draw on to help identify moral distress and how to gain moral resilience. The researcher created the following outline for the education program and provided it, along with materials attached in the appendix, to the participant nurses:

1. Review Nursing Code of Ethics

2. Review Ethics Committee Policy for Ellis Medicine

    a. Referral Process

3. Review Definitions

    a. Moral Courage
    b. Moral Distress
    c. Moral Resilience
    d. Sacred Covenant

4. Review Bioethics Principals for Nursing

    a. Justice
    b. Beneficence
    c. Non-malfeasance
    d. Accountability
    e. Fidelity
    f. Autonomy

g. Veracity

5. Review Theological Principals

    a. Scripture
    b. Tradition
    c. Reason
    d. Experience
    e. Community

6. A Case Study

7. Tools to Develop Moral Resilience

    a. Pavlish and Brown-Saltzman SUPPORT model as a resource/tool

The nurse participants came to the education sessions with eager attitudes, asked clarifying questions, and commented that the training and education materials will help them in their nursing practice. All five nurses verbalized, without prompting, that the education and training this researcher provided would be beneficial to all nurses at Ellis Medicine, but especially all new nurses as part of their orientation to Ellis Medicine.

The researcher created a survey of eight questions for the nurse participants to complete immediately following their education and training session. The survey was created using an online platform with questionpro.com, and the link was provided by either text or email to the nurse participants immediately following their education and training with the researcher. All five nurse participants completed the survey. The survey consisted of eight questions; six yes/no questions, two likelihood questions, and one open descriptive question as follows:

1. Did your participation in this study help you reflect on ethics and moral distress in nursing practice at a deeper level?

2. Did your participation in this study help you to have a better understanding of moral courage, moral distress, moral resilience, and sacred covenant?

3. Did your participation in this study help you to have a better understanding of bioethics principles for nursing practice?

4. Did your participation in this study help you to better understand theological principles of ethical reflection?

5. Do you think the SUPPORT model provided will help you in limiting moral distress and gaining moral resilience in your nursing practice?

6. Do you think the education you received in this study would be helpful for other nurses in their ability to make ethical decisions in their nursing practice?

7. How likely are you to be more aware of moral distress in your nursing practice after having participated in this study?

8. How likely are you to participate in more educational opportunities on ethical decision making in nursing practice if opportunities are offered by Ellis Medicine?

9. Please describe your experience of participating in this study.

All participant nurses completed the survey at the end of this research project. Four of the nurses completed the survey immediately after the education program. The researcher had to contact one of the nurses three times over a one-week period before she completed the survey.

Chapter 4

Results

Initial Interview

While the researcher for this project had hoped to recruit more participants, the five nurses who did participate were a fair representation of the nurses working in the ICU and ED at Ellis Hospital. As noted earlier in this thesis, males represent roughly eleven percent of nurses in the USA, and Ellis Hospital mirrors that statistic. The one male participant in this research project did not express anything specific about being a gender minority in the nursing profession. As will be noted in more detail later, the male participant expressed the same issues that create barriers to ethical decision making in healthcare, which leads to moral distress, as did the female participants.

The participants that are newer to nursing practice voiced eagerness to get bachelor's degrees in nursing; all voiced the importance of continuing education in nursing. They spoke about the anticipated changes in New York State licensing requirements that all nurses must have bachelor's degrees. On the other hand, the older, more experienced nurses seemed confident and comfortable with their associate's degrees in nursing and did not seem interested in pursuing bachelor's degrees. The older, more experienced nurses leaned into their years of experience as their greatest asset to nursing practice. The participant nurse with the most years of experience already has a bachelor's degree, and her role in the Emergency Department is to educate nursing staff.

This research project indicates that nurses in the ED and the ICU face some of the most challenging healthcare cases and are very likely to face situations that raise ethical questions while providing nursing care to their patients. All of the nurses interviewed for this research

project did not hesitate to describe significant ethical dilemmas they had faced in their nursing practice. The participant nurses described feeling significant stress when faced with ethical dilemmas. Kumar et al. note the overall stress level among ICU doctors and nurses is 52.43%.[65]

Table 4.1 Interview Question 1 Demographics

	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5
Gender	Female	Male	Female	Female	Female
Degree	AS; working on BS	AS; working on BS	AS	AS	BS
Work Area	ED	ICU	ICU	ICU	ED
Time as RN	1 year	2 years	15 years	29 years	40 years
Past Religion	None	Protestant	Catholic	Protestant	Catholic
Current Religion	None	Protestant	None	Protestant	None

All of the participant nurses were able to give a general definition for ethics in healthcare, but none were able to give a textbook definition of ethics in healthcare. The general theme for the nurses' definition of ethics in healthcare focused on doing the right thing for their patients. One nurse mentioned the Hippocratic Oath—"First, do no harm." All of the nurses spoke about morality when describing ethics in healthcare. One nurse described ethics as a moral compass. Some of the nurses connected the moral compass to their previous or current religious beliefs or the religious beliefs of any patient they may be caring for. One of the nurses spoke about nurses and patients having a social contract with one another; she described the social contract as a trusting relationship between the patient and the nurse. As the nurses spoke about social contract

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[65] Arunesh Kumar, Prasad Pore, Sachin Gupta, and Azizo Wani. "Level of Stress and Its Determinants among Intensive Care Unit Staff." *Indian Journal of Occupational and Environmental Medicine* 20, no. 3 (2016): 129.

and connected social contract with religious beliefs, they were in essence talking about a covenant.

All of the participant nurses stayed focused on the care of the patient throughout the interviews. There was never a mention of healthcare as a business or patients as consumers. O'Brien's sacred covenant model of nursing seems to be implied in how the participant nurses approach their practice, even if they do not describe it specifically as sacred covenant. As discussed in the literature review, O'Brien's sacred covenant model is focused on spirituality and theology rather than business and consumerism.[66]

The participant who has been in nursing for 40 years spoke about a class she took on healthcare ethics during her nursing education. She described the class as the most difficult class she took as part of her nursing education and stated she was grateful to be involved in this research project so that she could refresh her memory on some of ethical principles that may not have been developed when she took the ethics class so many years ago. She spoke about the challenge of ethical reflection and how there is no correct or hard and fast answer in ethics, but there is a best answer. Another challenge mentioned was the different world views that people bring to the table when they are engaging in ethical reflection to resolve an ethical dilemma.

Description of an Ethical Dilemma

There were common themes that emerged from participant nurses when they were asked to describe an ethical dilemma they had experienced as part of their nursing practice and what they did about it. The four primary themes related to conflict with a healthcare agent or surrogate, organizational hierarchy, power dynamics between physicians and nurses, and the

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[66] Mary Elizabeth O'Brien, *Spirituality in Nursing.*

religious beliefs of patients. There were other themes that emerged individually for the

participant nurses as well.

Table 4.2 Causes of Ethical Dilemmas

	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5
Healthcare Agent Decisions	Y	Y	Y	Y	Y
Homophobia		Y			
Misogyny			Y		Y
Organizational Hierarchy	Y	Y	Y	Y	Y
Power Dynamics (Physician/Nurse)	Y	Y	Y	Y	Y
Racial Disparities					Y
Religious Beliefs of Patient	Y	Y	Y	Y	Y

Y = Yes, Participant nurse mentioned this as part of the interview

All of the nurses spoke about ethical dilemmas that involved a patient they had cared for

who did not have capacity to make healthcare decisions and a healthcare agent previously

appointed by the patient, or a legally identified surrogate who was in a position to make

decisions for the patient. The dilemmas described involved a critically ill patient where

continuing medical interventions would potentially, but not likely, keep the patient alive for

some period of time. However, based on all medical evidence available, the patient would

experience pain, suffering, and a prolonged dying process as a result of the healthcare agent or

surrogate insisting on continued medical interventions. All of the participant nurses described

feeling helpless to do what they felt was the right thing, which would have been placing the

patient on comfort care and allowing a natural, peaceful death rather than extraordinary medical interventions to prolong life for a short period of time.

The participant nurses stated the attending physician in their specific cases spoke with the agent or surrogate and explained that ongoing medical interventions would not likely result in the patient being able to survive without the help of mechanical ventilation, and even then, their loved one would suffer and eventually die. The participant nurses stated they also spoke with the agent or surrogate to reiterate the physician's prognosis and recommendation, but in most cases the agent or surrogate became aggressive, angry, and withdrew from any further discussion about moving toward comfort or hospice care in those situations. As the nurses described the barriers in providing moral and ethical nursing practice, their voices became inflected when expressing their frustration and then somber when they expressed their sadness. All of the participant nurses indicated they took comfort in knowing they had no option except to do their best, and they all felt they did their best to help their patients to the best of their ability.

Beside the ethical dilemma of providing medical care that is in line with best practices of medical standards, conflict with a healthcare agent or surrogate also created moral distress. The participant nurses described feeling that they were prevented from doing what would have been considered best medical practice, and they were also prevented from doing what they felt was morally best for their patient.[67] Some described feeling they engaged in immoral practice; they were able to resolve this internal conflict through their knowledge that they were organizationally and legally bound to provide the medical interventions demanded by the agent or surrogate. In the end, the nurses tried to manage the dilemmas they described on their own in

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[67] A. Jameton, *Nursing Practice: The Ethical Issues.*

collaboration with the medical team assigned to the patient, except in a few situations when the seasoned nurses did call for an ethics consultation.

All of the nurse participants had some knowledge that Ellis Medicine has an ethics committee, but they were not able to clearly describe the role of the ethics committee and how to access the ethics committee for consultation. This lack of knowledge on the role of the ethics committee seems to have hindered their thinking to call on the ethics committee for help with this kind of ethical dilemma and conflict resolution. The two most experienced nurse participants noted they had called for an ethics consultation in the past, but it was clear they had experienced other ethical dilemmas where they did not call for an ethics consult, and lacked specifics about the role of the ethics committee and details on the process of making an ethics committee referral.

Annas and Grodin note that the role of the medical ethics committee has changed over the years.[68] They note that the medical ethics committee now has a significant role in conflict resolution between the patient, their family, and the medical team providing care. Unfortunately, the participant nurses exhibit some thinking that the medical ethics committee is limited based on policy or law. In reality, the ethics committee can be very helpful in conflict resolution and provide support to the medical team in coping with moral distress.

Hierarchy and Organizational Power Dynamics

All of the participant nurses spoke of deep respect for physicians, but they all also spoke of feeling that some physicians affiliated with Ellis Medicine did not value their clinical opinions. This seemed to have more to do with individual physicians than with the profession of

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[68] George Annas and Michael Grodin. 2016. "Hospital Ethics Committees, Consultants, and Courts." May 1. https://journalofethics.ama-assn.org/article/hospital-ethics-committees-consultants-and-courts/2016-05#:~:text=Although%20hospital%20ethics%20committees%20can,a%20successful%20lawsuit%20approaches%20zero.

physician itself. Some of the nurses had previously worked in other medical environments, which means they had other organizations and cultures to compare this barrier to.

For the female nurses, the gender of the physician played a role in the lack of value. One nurse stated she had witnessed misogyny. She described a pattern of male physicians walking into a patient room where a female physician was in charge of directing the treatment in an emergent situation and, with an aggressive approach, take control of directing the team away from the female physician. The nurse stated the male physicians who engage in this kind of behavior are not held accountable because it is not reported; fear of retaliation plays a part in reporting up in the organizational structure.

Another nurse participant spoke about a situation where a Black person came into the hospital with chemical withdrawal symptoms. The nurse stated the treatment given to the patient was clearly different than the treatment given to white patients with the same condition. The Black patient was not given medication to alleviate the pain and suffering of withdrawal that were given to white patients. The nurse stated she reported this to the proper chain of command, but she never heard whether there was any level of quality review or accountability. The nurse felt this was a failure in the organization structure and also an example of racial disparity in healthcare.

Prior to the New York State Law that required hospitals to allow domestic partners, and subsequently gay marriage, gay and lesbian life-partners were often prevented from visiting and participating in healthcare decisions for their loved ones.[69] One nurse described feeling extremely stressed and disturbed when a gay man's partner was disallowed from visiting him in

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[69] Al Baker. "New Law Gives Gay Partners Visiting Rights in Hospitals." *New York Times*, last modified October 2, 2004. https://www.nytimes.com/2004/10/02/nyregion/new-law-gives-gay-partners-visiting-rights-in-hospitals.html.

the hospital. Even though this situation happened years prior to the changes in the law that now protects gay and lesbian married and domestic partnered people, the distress of the situation has stayed with this nurse for many years. She reported her distress to organizational leadership at the time, but she was not supported and clearly felt some moral injury because she was required to participate in the decision to disallow the patient's life-partner visitation and participation in making healthcare decisions.

Religious Beliefs

There was a good mix of Protestant and Catholic participant nurses; only two of the five participant nurses continue to be active in a community of faith. However, four of the five nurses spoke about religious beliefs impacting their moral and ethical decisions in nursing practice, while the one without any religious background indicated that spirituality plays a part in their practice. All of the participant nurses stated they would in no way impose their religious beliefs on a patient or family, but they stated they gained moral and ethical grounding through their past or present religious and spiritual beliefs.

The common theme that came out of the discussion on the participant nurses' religious or spiritual beliefs centered on doing what is right, good, helpful, and compassionate in all aspects of life, which includes their nursing practice. The was no difference between understanding of the basic Christian principle of caring for the sick and dying. None of the participant nurses quoted scripture or dogma, but it was clear in the interviews that scripture and religious tradition has impact on their moral and ethical thinking. The nurses who spoke about their religious experiences shared more about their community of faith and how people in those communities had a positive impact on their understanding of morality and ethics than they did the specific tenants or teachings of their religious tradition.

When the researcher asked the participant nurses how the religious beliefs of a patient or family impact the participant nurses' response to and ethical dilemma, none of the nurses spoke about having inquired about the religious beliefs of the ethical dilemmas they had previously delt with. However, all of the nurses spoke about the importance of patient and family religious beliefs in ethical decision making. All of the nurse participants spoke about the pluralistic makeup of the patient and family population at Ellis Medicine, and they all verbalized their commitment to honoring and taking into consideration the religious beliefs of the patient and family in their nursing practice.

One of the nurses spoke about the difference in cultural norms within various Christian traditions, as well as other religions. The nurse spoke about how some cultures become more emotional at the bedside when their loved one is dying. The nurse stated there tends to be a more apparent negative reaction to families that express their grief through crying out, or wailing at bedside. The nurse stated she feels her role is to protect these families so they have the space to grieve and mourn in their own way when other staff may try to intervene, suppress, or even remove the family due to lack of understanding of their culture.

Following the interviews, the researcher noted that it would have been helpful to ask the nurses if they have any preference in working for a secular or religious healthcare organization. The nurses at Ellis Medicine are not bound by any religious doctrine as part of their practice. If this research project was conducted in a hospital affiliated with a religious organization, the nurses' answers may have been influenced by the ethical and moral principles of the religious affiliate. Whereas, at Ellis Medicine the ethical and moral principles are based on secular, bioethics principles, there is no indication that working at a secular hospital influenced the nurses' answers regarding the impact of religion on their practice. However, this secular leaning

at Ellis Medicine came through when the researcher provided education to the participant nurses in the final phase of the project. None of the nurses knew about the theological, ethical principles of scripture, tradition, experience, and reason.

Education on Ethical Decision Making

All of the participant nurses stated they had received some education on bioethics and ethical decision making as part of their nursing education. However, the education was cursory at best and did not include a full course on ethics in nursing practice. All of the participant nurses stated they felt their nursing education program should have included a full course in ethical decision making. They all stated they realized early on in their nursing career that ethical decision making is a big part of their role in nursing.

With regard to the continuing education offered at Ellis Medicine, all of the nurses stated they receive good continuing education as part of their job. Ellis Medicine has a director of nursing education and there are regular education requirements rolled out from the Nursing Education Department that all nurses are required to meet. Unfortunately, an in-depth study of ethics in nursing practice is not one of the offerings. Nurses at Ellis Medicine do have ethics education available to them through a program called HealthStream, but the nurses would need to seek out the education program on their own.

Approximately two years ago, a member of the Ellis Ethics Committee would provide a one-hour education session to all graduate or new nurses on the role of the ethics committee and the different kinds of cases that may be referred for a consultation from the ethics committee. In an effort to streamline and shorten the onboarding process for graduate or new nurses, the presentation from the ethics committee was cut from the orientation. The two longest-tenured

participant nurses mentioned this as part of their interview and stated they felt it was a mistake to cut the ethics committee presentation from the orientation program for graduate or new nurses.

Barriers to Good Ethical Decision Making

The participant nurses spoke about several barriers to good ethical decision making in their nursing practice. All of the nurses mentioned power dynamics between doctors and nurses. Nurses spend many hours with patients and families and get to know them on a very personal level. Nurses also spend the most time doing the hands-on work of implementing physicians' orders. However, the physicians have the final say when there is a question of what path to take in the plan of care. All of the participant nurses stated that physicians sometimes make decisions about a patient under their care without consulting with them and, the nurses feel their input on those decisions could have been helpful to the patient, family, and doctor.

The participant nurses also spoke about legal, policy, and organizational barriers. The State of New York requires the medical team to follow the demands of a patient's healthcare proxy or surrogate decision maker as long as those demands are for life-sustaining measures and within the scope of normal medical practice. All of the participant nurses spoke about cases where the healthcare proxy or surrogate decision maker was making decisions about medical care that did not appear to be in the best interest of the patient.

It is not allowable by law or policy to go against the wishes of a healthcare proxy or surrogate decision maker, because they speak as if they are the patient. The policies of Ellis Hospital are written to comply with the legal requirements that the healthcare team must follow the wishes of a healthcare agent or surrogate decision maker, except in limited circumstances that would mandate the involvement of the Ellis Medicine Ethics Committee. Further, those in the highest level of decision-making power within Ellis Medicine would have no choice but to

follow the insistence that the medical team follow the wishes of the patient appointed healthcare agent or surrogate decision maker.

As our society has become less religious, it has also become more demanding that people be kept alive because there is a lack of faith, hope, and confidence in God.[70] Sacred scripture offers ultimate hope for people who understand that life is impermanent. As the Apostle Paul said in Romans 8:28, "For I am convinced that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor any other created thing will be able to separate us from the love of God that is in Christ Jesus our Lord." Also, our Lord said, according to John 14:2, "In My Father's house are many rooms; if that were not so, I would have told you, because I am going there to prepare a place for you." First Thessalonians 4:13 is important in this matter: "We do not want you to be uninformed, brothers and sisters, about those who are asleep, so that you will not grieve as indeed the rest of mankind do, who have no hope."

The participant nurses clearly understand the impermanence of human life and they all expressed their heartache because of the overuse of life sustaining medical treatments to keep people alive. One may interpret this as an interference with what God wishes. Theologically, there is a power struggle between the human will and God's will. The participant nurses were not able to articulate this in theological terms, but they all have clearly experienced such a power struggle between life, death, and the afterlife.

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[70] "In U.S., Decline of Christianity Continues at Rapid Pace." Pew Research Center's Religion & Public Life Project, last modified June 9, 2020. https://www.pewforum.org/2019/10/17/in-u-s-decline-of-christianity-continues-at-rapid-pace/.

The Impact of Education

The education program this researcher provided for the participant nurses was structured and planned to give a high-level overview of medical ethics in nursing practice, the practical aspect of making an ethics consult request at Ellis Medicine, theological principles in ethics, a case study, and some tools to build moral resilience. Since sacred covenant and the SUPPORT model were core features of the education program, this researcher made sure to keep these two areas at the forefront of the entire education program for the participant nurses. During the time of education with the nurses, this researcher connected the idea of a social contract with the general understanding of sacred covenant. This seemed to help the nurses grasp the understanding of how trust is a major aspect of sacred covenant and also how sacred covenant is often, even if unknowingly, a part of nursing practice.

This research highlighted Provision 5 of the Nurses Code of Ethics, which holds nurses accountable for self-care. Throughout the interviews with the nurse participants, the nurses focused their reflections, answers, and comments on the care of their patients and families, along with commentary on relationships as they relate to other medical professions, organizations, and governmental requirements. Self-care did not seem to be at the forefront of the nurses' personal ethics, nor did they seem to have a solid understanding of how important self-care is to their nursing practice.

All of the nurses responded well to having received standard ethical, moral, and biblical language to give definition to much of what they already knew deep down, but were unable to give that definition prior to the education provided. They all stated they would keep the written resources provided and stated they would use the written materials to guide them in searching out more information on medical ethics, moral distress, and moral resilience. This researcher suggested the nurse participants share their newfound knowledge with their colleagues.

One of the nurse participants in this study expressed interest in joining the Ellis Medicine Ethics Committee. This nurse submitted the necessary documents to apply and was approved to join the ethics committee. The ethics committee is required by policy to have at least one nurse. With the addition of this nurse participant, the ethics committee will have three nurse representatives.

The nurse participants found the SUPPORT model to be an excellent outline of concrete suggestions to mitigate moral distress and to guide actions that they may take to improve analysis of ethical dilemmas in their nursing practice. The SUPPORT model encourages nurses to engage and access stakeholders to help address ethical dilemmas. When these resources are added and adequate debriefings are held following complicated ethical dilemmas, nurses are more resilient and better able to mitigate moral distress.

Following the education program with the participant nurses, they each completed a survey which showed the impact of the research and research program for this project.

Figure 4.1 Survey Overview

Survey Overview

Completion / Dropout

0

■ Completed
■ Drop Out

5

Figure 4.2 Survey Question 1

Did your participation in this study help you reflect on ethics and moral distress in nursing practice at a deeper level?

120%

100.00%

100%

80%

60%

40%

20%

0.00%

0%

Yes   No

Mean : 1.000 | Confidence Interval @ 95% : [1.000   - 1.000] | Standard Deviation : 0.000 | Standard Error : 0.000

Figure 4.3 Survey Question 2

Did your participation in this study help you to have a better understanding of moral courage, moral distress, moral resilience, and sacred covenant?

120%

100.00%

100%

80%

60%

40%

20%

0.00%

0%

Yes   No

Mean : 1.000 | Confidence Interval @ 95% : [1.000   - 1.000] | Standard Deviation : 0.000 | Standard Error : 0.000
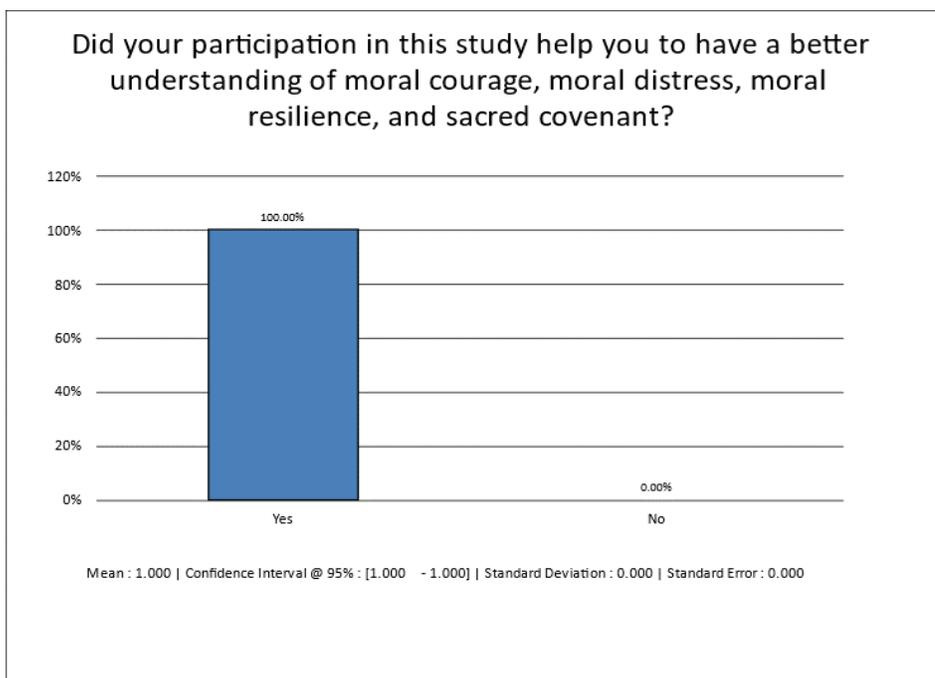
Figure 4.4 Survey Question 3

Did your participation in this study help you to have a better understanding of bioethics principals for nursing practice?

Mean : 1.000 | Confidence Interval @ 95% : [1.000   - 1.000] | Standard Deviation : 0.000 | Standard Error : 0.000
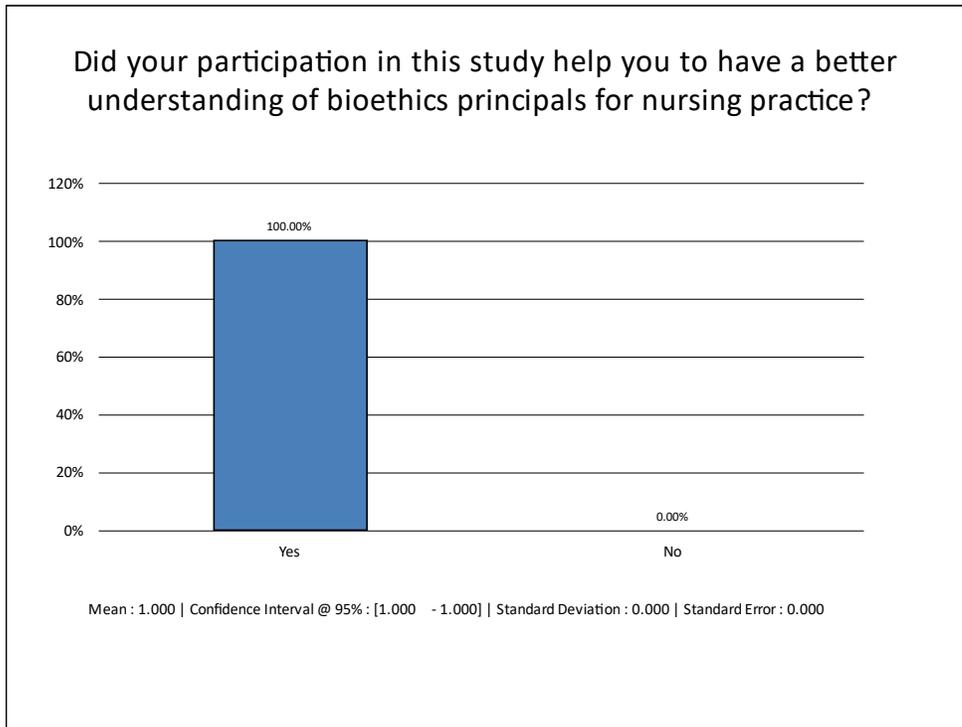
Figure 4.5 Survey Question 4

Did your participation in this study help you to better understand theological principals of ethical reflection?

Mean : 1.000 | Confidence Interval @ 95% : [1.000   - 1.000] | Standard Deviation : 0.000 | Standard Error : 0.000

69
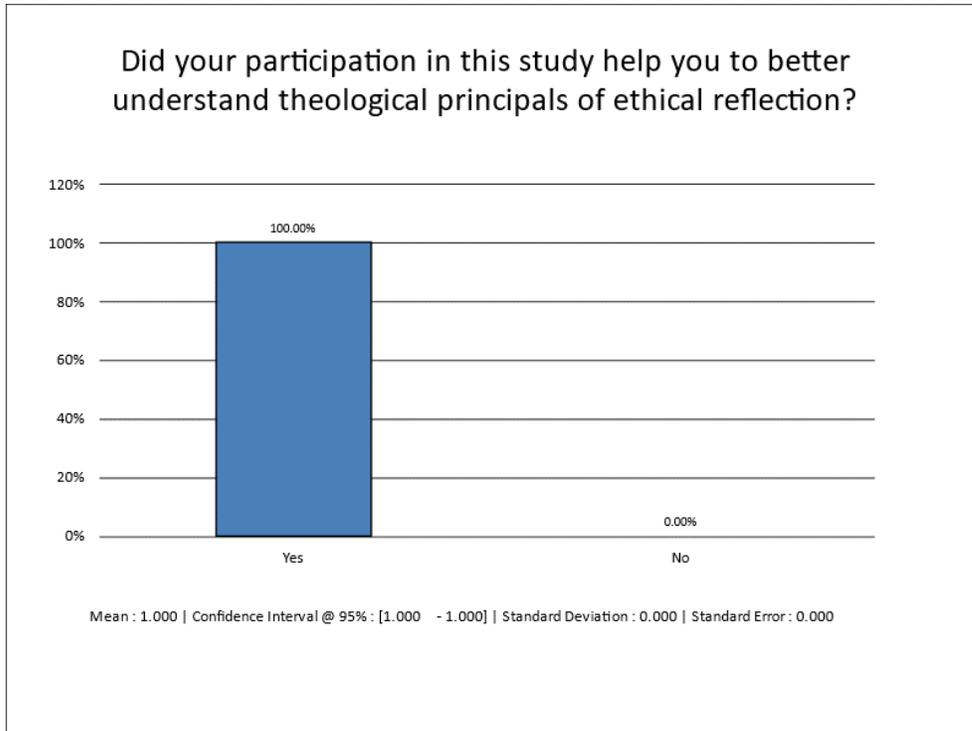
Figure 4.6 Survey Question 5

Do you think the SUPPORT model provided will help you in limiting moral distress and gain moral resilience in your nursing practice?

Mean : 1.000 | Confidence Interval @ 95% : [1.000   - 1.000] | Standard Deviation : 0.000 | Standard Error : 0.000
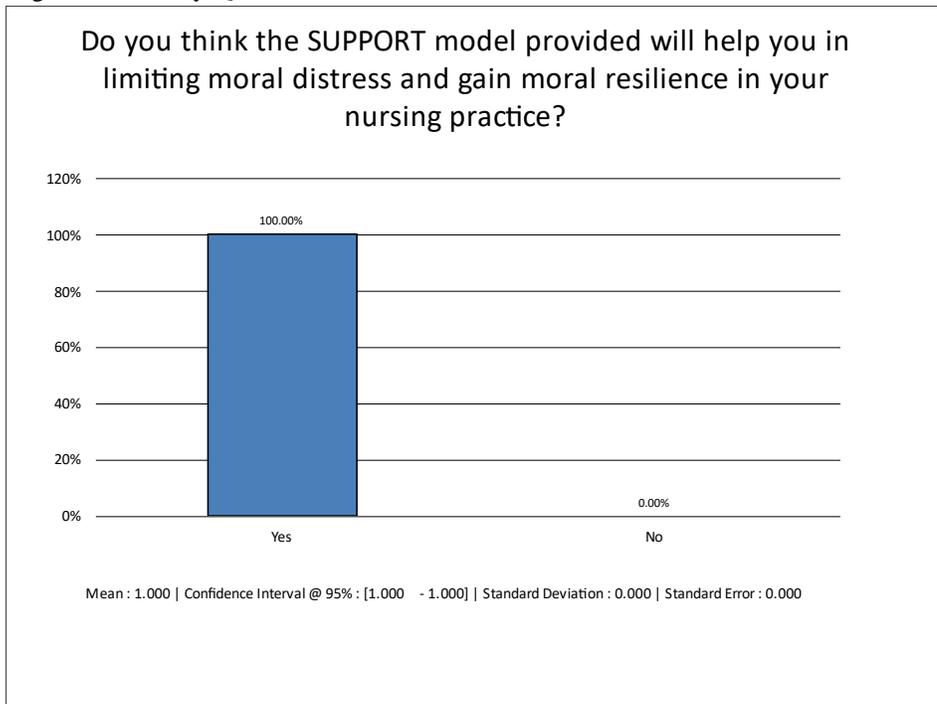
Figure 4.7 Survey Question 6

Do you think the education you received in this study would be helpful for other nurses in their ability to make ethical decisions in their nursing practice?

Mean : 1.000 | Confidence Interval @ 95% : [1.000   - 1.000] | Standard Deviation : 0.000 | Standard Error : 0.000
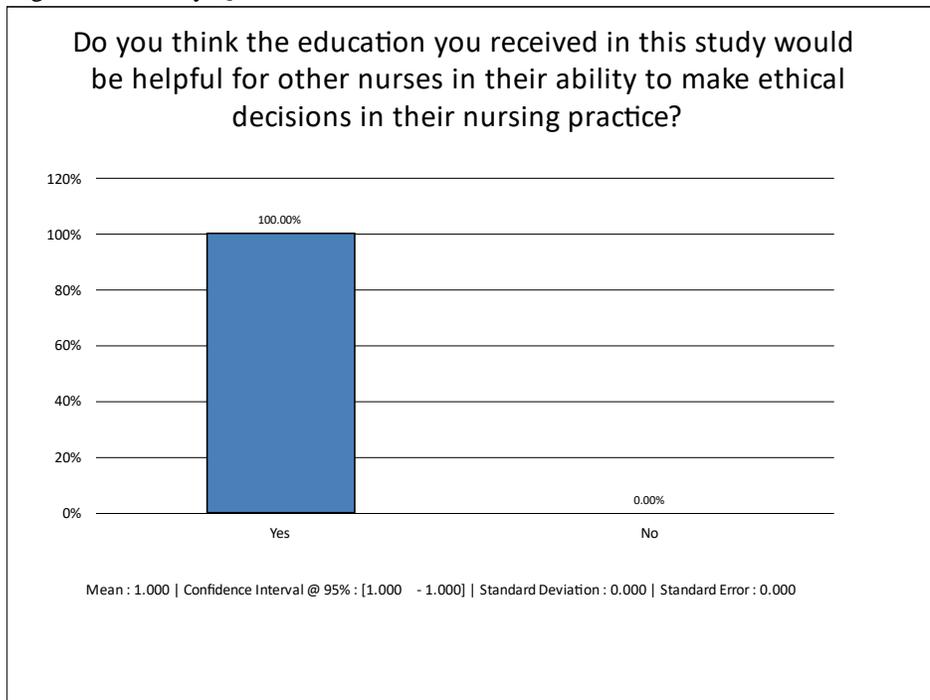
Figure 4.8 Survey Question 7

How likely are you to be more aware of moral distress in your nursing practice after having participated in this study?

1. Likelihood of Awareness

4.6
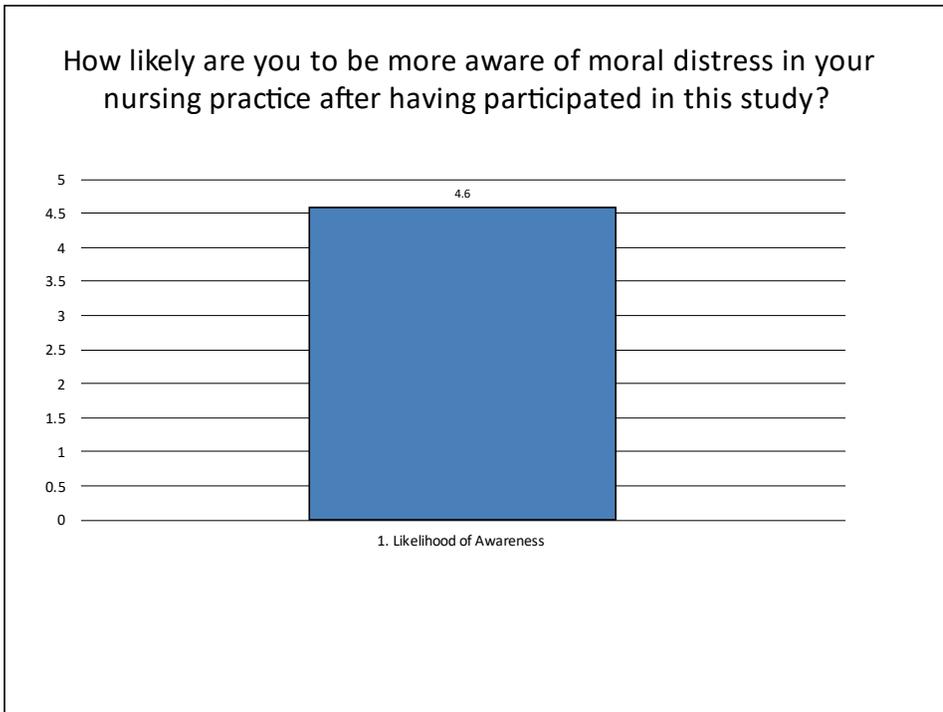
Figure 4.9 Likelihood of Awareness

Likelihood of Awareness

| Not Likely At All | Not Likely | Somewhat Likely | Likely | Very Likely |
0.00% | 0.00% | 0.00% | 40.00% | 60.00%

Mean : 4.600 | Confidence Interval @ 95% : [4.120   - 5.080] | Standard Deviation : 0.548 | Standard Error : 0.245
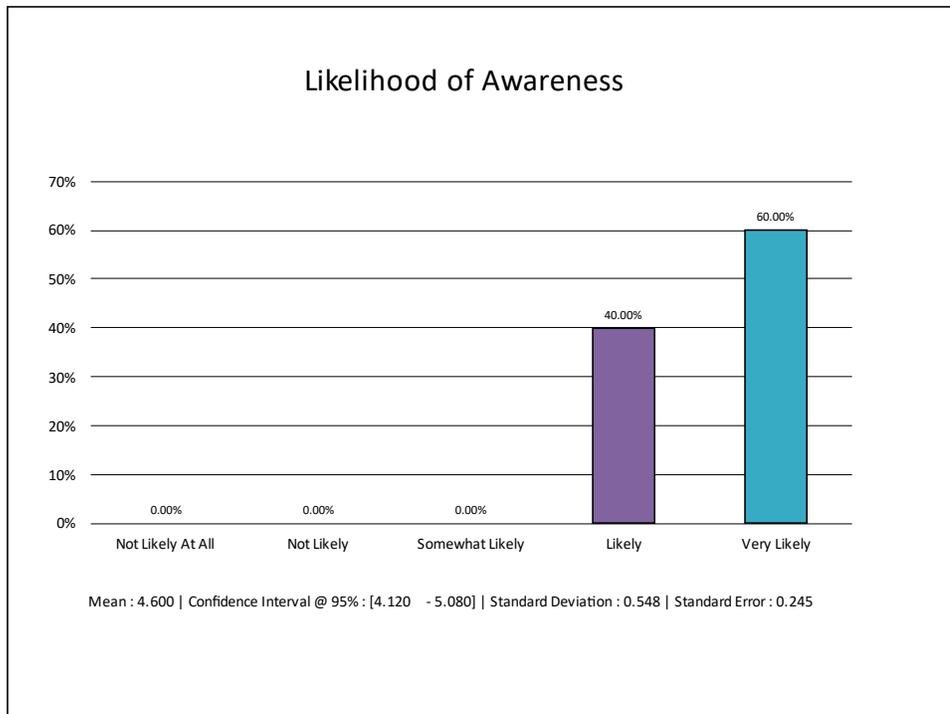
Figure 4.10 Survey Question 8

How likely are you to participate in more educational opportunities on ethical decision making in nursing practice if opportunities are offered by Ellis Medicine?

4.8

1. Likelihood of More Ethics Education

Figure 4.11 Likelihood of More Ethic Education

Likelihood of More Ethics Education

80.00%

20.00%

0.00%   0.00%   0.00%

Not Likely At All   Not Likely   Somewhat Likely   Likely   Very Likely

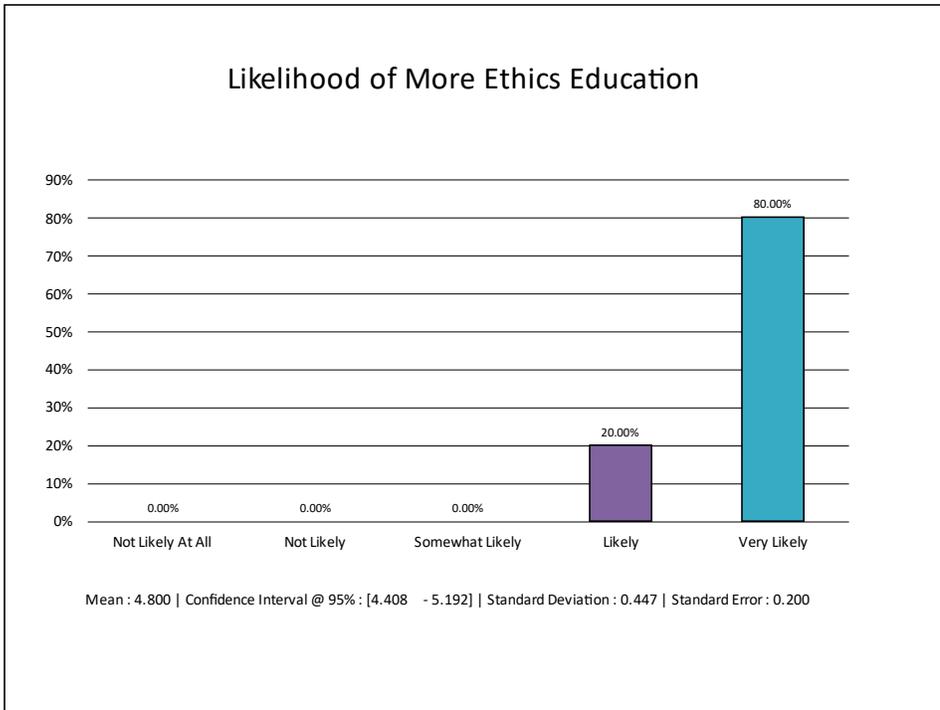Mean : 4.800 | Confidence Interval @ 95% : [4.408   - 5.192] | Standard Deviation : 0.447 | Standard Error : 0.200

Figure 4.12 Description of Survey Experience

Please describe your experience of participating in this study.

Response ID	Response
76374646	Through conversations with Fr Tony Green many scenarios where discussed and different opinions where expressed dealing with moral, religious, and cultural beliefs and these discussions always open up a new outlook and hopefully help the healthcare worker to understand and relate to the pt or pt family's needs and frustrations during care of the pt and or loved one....
75515248	I am grateful for the opportunity to reflect and discuss my experiences with Tony. I am hopeful this model can be incorporated into the GN residency program
74885239	Thank you for allowing me to participate in this study. I believe ethical decision making is an essential aspect of providing proficient patient care while in the intensive care unit. This study has provided me with resources that I was not previously aware of, specifically regarding consulting the ethics committee on behalf of a patient. I hope this area is further incorporated into our critical care training during the new hire process.
74257633	I found this study to be very informative on the resources available for nurses. It helped me reflect on my own strategies for handling moral/ethical issues as well as the support system available to me.
74062906	able to discuss a morally distressing case and able to review ethical policy and resources available to us

The data from the survey indicate that all of the nurses benefited from the research project and the education component provided did have the intended effect of limiting moral distress and increasing moral resilience in the participant nurses' nursing practice. The survey indicated a slight drop in the nurses' likelihood of awareness of moral distress in their nursing practice. Additional research may need to be done on how to raise the likelihood of increasing nurses' awareness of moral distress in their nursing practice. This researcher hypothesizes that nurses are so focused on their tasks and keeping up with their workflow, along with a lack of awareness of the importance of self-care, that these factors inhibit their ability to be fully aware of the moral distress that is present in their practice.

Chapter 5

Conclusion

Today's healthcare system and medical interventions are very complex. The complexities in healthcare and, in particular, nursing practice have put an additional strain on nurses' ability to make good ethical, moral, biblical decisions in the care of their patients. The barriers nurses face in making good ethical, moral, biblical decisions lead to moral distress. Research has shown that interventions to help nurses make good ethical, moral, biblical decisions can lower moral distress and increase moral resilience, but there is limited research that shows the impact of interventions to lessen moral distress and raise moral resilience. The intervention for this research project provides evidence that an educational program that teaches nurses some principles of making good ethical, moral, biblical decisions lessens their moral distress and increases their moral resilience.

This research project was done during the COVID-19 pandemic, which significantly raised the amount of moral distress in nursing practice. Primarily, the moral distress stemmed from nurses' inability to provide care and support to their patients in a way that fully honored their worth and dignity. Nurses were overwhelmed with the number of people who needed their care. Therefore, because the number of patients needing care was so high, and the risk of communicable disease was so high, nurses could not provide the same amount of time caring for their patients as they otherwise would. Additionally, many nurses, along with other medical staff, were taken out of the workforce for two weeks or longer when they had an exposure or became infected with COVID-19. There is already a nursing shortage nationwide, so this high frequency of nurses either quarantining or recovering from COVID-19 exacerbated this struggle.

As noted earlier, overall, nurses will say that their loyalty lies with their patient and they have a duty to doing good for their patient. The pandemic created a global situation where nurses' loyalty to the patient was challenged at a deep level. Nurses questioned policy decisions by hospital administration, government officials, and even their peers with regard to safety measures, visitation policy, distribution of limited medical supplies, and the kind of emotional support they needed. The participant nurses for this research project made it clear that their number-one priority has been and always will be loyalty to the patients and families they care for. While the pandemic may have added a challenge to this loyalty factor, the nurses took every opportunity to voice any concerns they had that would threaten their loyalty and ethical duty.

In collaboration with the Human Resources Department, chaplains increased emotional and spiritual support of nurses at Ellis Medicine during the pandemic. The participant nurses noted during their interviews that this project was very helpful and timely during the pandemic. They all verbalized feeling a need for more resources to help with their coping when they are under moral distress.

A bonus resource that followed alongside the SUPPORT model was the implementation of a Code Lavender policy at Ellis Medicine. This researcher was a part of the Code Lavender Development Team. The development team included a nurse leader and other stakeholders within the organization. This researcher is the owner of the Code Lavender Policy and is assigned a leadership role in responding when a Cod Lavender is initiated.

A Code Lavender involves a quick response team to support nurses, or other clinical staff, when they reach the point of debilitating stress that disrupts their ability to adequately perform their nursing duties. The Code Lavender is usually called by a colleague or supervisor who sees that a nurse is in need. The response team includes a chaplain; it is noted that prayer,

along with a calm environment and supportive counsel, are proven techniques for intervention. The Code Lavender is a short, immediate intervention and is not meant to replace long-term interventions for people who need ongoing support from a professional counselor or medical provider. See Appendix C for the Code Lavender policy and process.

The advancement and success of new interventions in modern medical care have proven to be of great benefit to quality of life and the ability to help humans live longer. This is a blessing from God. However, along with those medical advancements and successes come more complicated theological questions. The participant nurses in this project represent an overall lack of knowledge and integration of theology when reflecting on ethical dilemmas in healthcare. This is why it is important for chaplains to be involved as critical stakeholders when ethical dilemmas rise up.

The participant nurses for this project came to the table with a variety of experiences and had very strong opinions about the great things happening in healthcare to help God's people, along with very strong opinions about the failures and challenges. It became clear to this researcher that the medical system can too easily try to play God rather than rely on God as the ultimate guiding force in the good works that are done for God's people. It is worth returning to Philippians 2:4–8:

> Let each of you look not to your own interests, but to the interests of others. Let the same mind be in you that was in Christ Jesus, who, though he was in the form of God, did not regard equality with God as something to be exploited, but emptied himself, taking the form of a slave…he humbled himself and became obedient to the point of death—even death on a cross.

In conclusion, it is imperative that nurses' education, training, and work culture include education on secular and religious ethical decision making, moral distress, and moral resilience, and that they be given tools such as the SUPPORT model to help in building moral resilience.

Additionally, medical systems, such as Ellis Medicine, will need to do a retrospective on the moral distress that resulted from the COVID-19 pandemic so the organization, and the medical system as a whole, can be better prepared to mitigate moral distress at such an extreme level. Finally, using the insight gained from this research project, this researcher hopes to submit a proposal to Ellis Medicine's Bellanger School of Nursing to offer an elective ethics class as part of the curriculum.

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Appendix A

Liberty University

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

April 20, 2020

Anthony Green
Kenneth Bush

Re: IRB Exemption - IRB-FY19-20-263 Ethics in Nursing Practice: The Impact on Moral Distress

Dear Anthony Green, Kenneth Bush:

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46: 101(b):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. This form should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Ellis Medicine

Ellis
MEDICINE

Bellevue Woman's Center
Ellis Health Center
Ellis Hospital

1101 Nott Street   Schenectady, New York 12308   ███████████   www.ellismedicine.org

March 26, 2020

Bp. Anthony W. Green, M.Div., BCC
Ellis Medicine

Re: Ethics in Nursing Practice: The Impact on Moral Distress Study

Dear Father Green:

Thank you for submitting a proposal to the Ellis Hospital Institutional Review Board (IRB00008111). Under the expedited review process, Chairperson Marilyn Stapleton has reviewed and approved of the protocol and other materials presented for the above-mentioned study. This study was approved for 6 months with a final report due at the September 2020 meeting.

As a reminder, no additional changes may be made to this project without first submitting the changes to the IRB for approval. If you decide to have a third party transcribe your recordings, please inform the IRB as soon as possible. Any inquiries or unanticipated problems must also be promptly reported.

Thank you for your continued interest in research.

Sincerely,

████████████████

Emily Spinner, MSIS, MA
Administrator
Institutional Review Board

cc: Marilyn Stapleton, Chairperson
       Eun Hae Kim
       Tasha St. John

Appendix B

Ethical Decision Making in Nursing Practice: The Impact on Moral Distress

Education Outline for Participant Nurses

Prepared by: Rev. Anthony W. Green, M.Div., D.Min. Candidate

1. Review Nursing Code of Ethics

2. Review Ethics Committee Policy for Ellis Medicine

    a. Referral Process

3. Review Definitions

    a. Moral Courage
    b. Moral Distress
    c. Moral Resilience
    d. Sacred Covenant

4. Review Bioethics Principals for Nursing

    a. Justice
    b. Beneficence
    c. Non-malfeasance
    d. Accountability
    e. Fidelity
    f. Autonomy
    g. Veracity

5. Review Theological Principals

    a. Scripture
    b. Tradition
    c. Reason
    d. Experience
    e. Community

6. A Case Study

7. Tools to Develop Moral Resilience

    a. Pavlish and Brown-Saltzman SUPPORT model as a resource/tool

TITLE:	NUMBER:	REVISED DATE:	OWNER:
Ethics Committee	1101	November 2018	Ethics Committee, Chairperson
CROSS REFERENCES: **Policy 7005 Advance Directives & Surrogate Decision Making** **Policy 7060 Determination of Death** **Policy 7043 Informed Consent** **Policy 7340 Refusal of Care**			

INTRODUCTION

The Ethics Committee is designated to serve in an advisory capacity with respect to ethical issues that may arise concerning the care of patients, as well as issues that may arise in organizational decision making. The Ethics Committee also provides advice, assistance, and education concerning medical ethics.

PURPOSE OF POLICY

To define the role and membership of the Ethics Committee

To detail the process for requesting an ethics consult

To describe the administrative process/functions of the Ethics Committee

SCOPE

The Ethics Committee can be accessed by all patients, their family members and healthcare proxy, surrogate decision makers, guardians, and all staff, in all settings of Ellis Medicine.

PROCEDURES

Committee Structure

The Ethics Committee shall be interdisciplinary and shall be comprised of a minimum of five members. At least three members must be from the medical-dental staff, at least one of whom must be a registered nurse and one of whom must be a physician or nurse practitioner. Additionally, the committee must have at least one community representative, who has no other governance, employment, or contractual relationship with the hospital. The Committee may include such additional members as deemed desirable by consensus of the Ethics

Committee, including members of the clergy, social workers, and patient advocacy representatives. The Ethics Committee will review the credentials of individuals recommended or those who apply for a seat on the Ethics Committee. Candidates for a seat on the Ethics Committee will be appointed if there is a majority vote of the Committee to approve the candidate for a seat.

When attempting to mediate disputes concerning a patient deemed to lack capacity to consent to a DNR/DNI order, the Ethics Committee shall consult with a provider eligible to give a concurring determination under the law.

A. Meeting Schedule

The Ethics Committee shall meet at least four times per year. When necessary, special meetings of the Ethics Committee will be called to advise on particularly complicated patient issues.

B. Accessing the Committee

It is the intent of this policy to encourage involvement of the Ethics Committee in patient care when ethical issues arise.

Any patient, their family members or healthcare proxy, surrogate decision maker, guardian, or any provider or staff member may request an Ethics Committee consult. The nature of the situation will determine whether a special meeting of the Ethics Committee is called or if the situation can be clarified through conversation with one member of the committee who must also consult with a second member of the Ethics Committee for affirmation of any recommendation.

The request for an ethics consult may be directed to any Ethics Committee member, primary caregiver, department or division chief, hospital manager or director, or a member of hospital administration. Lines of organizational reporting do not have to be followed when making an Ethics Committee consult request.

The patient's case manager and/or social worker will be notified of the request for an Ethics Committee consult.

If the person receiving the request for the consult is not a committee member, that person will contact the hospital operator, who in turn will contact a member of the Ethics Committee. (Operators will be provided a list of Ethics Committee members.) The administrator on call will also have a list of committee members.

Members of the Senior Administrative Team may contact the Ethics Committee through the committee chairperson or their designee for consultations regarding institutional decision making.

C. Committee Process/Administration

Upon receiving a request for an Ethics Committee Consult, the Committee shall respond promptly, and a committee member shall confer with the person making the request. However, a person connected with the case may not participate as an ethics review committee member in the consideration of that case. An initial determination will be made by the Ethics Committee member receiving the consult request if the consult may be handled by an individual committee member or should be addressed by the entire Ethics Committee. Anyone directly involved in the patient's care may request a meeting of the full Ethics Committee at any time during the Ethics Committee's involvement.

i. Special meetings of the entire Ethics Committee will be called to advise on particularly complicated patient issues.

ii. Depending on the nature of the request, the patient, family members, healthcare proxy, attending physician, consulting physician, case manager, social worker and other members of the healthcare team will be invited to the Ethics Committee meeting for review.

iii. When it is determined that the entire committee is not needed, the individual Ethics Committee member involved in counseling will consult with another Ethics Committee member to minimize bias.

iv. The results of the discussions shall be reviewed with the entire Ethics Committee at the next regularly scheduled Ethics Committee meeting.

v. A member of the Ethics Committee shall document any recommendations and/or decisions in the patient's chart.

Persons participating as members or consultants to the Ethics Committee, and the Committee itself, shall not have the authority to determine if a physician's order shall be issued or if treatment shall be carried out or withheld, except as required by law. The patient, attending physician, and family determine the final decision for patient care.

The Ethics Committee shall report as necessary to Hospital Administration and MDEC the substance of its deliberations and recommendations on policy matters affecting hospital administration.

The Ethics Committee shall provide the dispute mediation system function required by Section 2972 of the Public Health Law.

D. Withhold or Withdraw Life-Sustaining Treatment

Following ethics review committee consideration of a case concerning the withdrawal or withholding of life-sustaining treatment, treatment shall not be withdrawn or withheld until the following individuals are provided with notice of the Committee's notice: the patient, where there is any indication of the patient's ability to comprehend the information; the surrogate; other persons on the surrogate list directly involved in the decision or dispute regarding the patient's care; any parent or guardian of a minor patient directly involved in the decision or dispute regarding the minor patient's care; an attending physician; an attending nurse practitioner; the hospital; and other persons the Committee deems appropriate.

E. Access to Records and Confidentiality

Ethics review committee members and consultants shall have access to medical information and medical records necessary to perform their function. The proceedings and records of an ethics review committee shall be kept confidential and shall not be released by committee members, committee consultants, or other persons privy to such proceedings and records except in accordance with Public Health Law 2994-m.

EXHIBITS

Deciding About Healthcare: A Guide for Patients and Families, NYS Dept. of Health

New York State Consolidated Laws, PHL 2994-m

New York State Consolidated Laws, PHL 2972

REFERENCES

ORIGINAL IMPLEMENTATION DATE: 7/15/08

REVIEW DATE: 8/11, 1/15, 1/17, 11/20

REVIEWED DATE: 8/08, 1/12, 8/15, 12/15, 10/17

REVISED: 1/5/12, 9/18, 11/18

REVIEWED BY:

Executive VP Strategy & Integration

Executive VP Operations/CNO

Chair, MDEC

Ellis Board of Trustees

New York Consolidated Laws, Public Health Law - PHL § 2994-m

Ethics Review Committees

1.   Establishment of an ethics review committee, written policy. Each hospital shall establish at least one ethics review committee or participate in an ethics review committee that serves more than one hospital, and shall adopt a written policy governing committee functions, composition, and procedure, in accordance with the requirements of this article. A hospital may designate an existing committee, or subcommittee thereof, to carry out the functions of the ethics review committee provided the requirements of this section are satisfied.

2.   Functions of the ethics review committee.

   (a) The ethics review committee shall consider and respond to any healthcare matter presented to it by a person connected with the case.

   (b) The ethics review committee response to a healthcare matter may include:

      (i) providing advice on the ethical aspects of proposed healthcare;

      (ii) making a recommendation about proposed healthcare; or

      (iii) aiding in resolving disputes about proposed healthcare.

   (c) Recommendations and advice by the ethics review committee shall be advisory and nonbinding, except as specified in subdivision 5 of section 2994-d of this article and subdivision 3 of section 2994-e of this article.

3.   Committee membership. The membership of ethics review committees must be interdisciplinary and must include at least five members who have demonstrated an interest in or commitment to patient rights or to the medical, public health, or social needs of those who are ill. At least three ethics review committee members must be health or social services practitioners, at least one of whom must be a registered nurse and one of whom must be a physician. At least one member must be a person without any governance, employment, or contractual relationship with the hospital. In a residential healthcare facility, the facility must offer the residents' council of the facility (or of another facility that participates in the committee) the opportunity to appoint up to two persons to the ethics review committee, none of whom may be a resident of or a family member of a resident of such facility, and both of whom shall be persons who have expertise in or a demonstrated commitment to patient rights or to the care and treatment of the elderly or nursing home residents through professional or community activities, other than activities performed as a healthcare provider.

4.   Procedures for ethics review committee.

   (a) These procedures are required only when:

(i) the ethics review committee is convened to review a decision by a surrogate to withhold or withdraw life-sustaining treatment for: (A) a patient in a residential healthcare facility pursuant to paragraph (b) of subdivision 5 of section 2994-d of this article;

(B) a patient in a general hospital pursuant to paragraph (c) of subdivision 5 of section 2994-d of this article; or

(C) an emancipated minor patient pursuant to subdivision 3 of section 2994-e of this article; or

(ii) when a person connected with the case requests the ethics review committee to aid in resolving a dispute about proposed care. Nothing in this section shall bar healthcare providers from first striving to resolve disputes through less formal means, including the informal solicitation of ethical advice from any source.

(b)

(i) A person connected with the case may not participate as an ethics review committee member in the consideration of that case.

(ii) The ethics review committee shall respond promptly, as required by the circumstances, to any request for assistance in resolving a dispute or consideration of a decision to withhold or withdraw life-sustaining treatment pursuant to paragraphs (b) and (c) of subdivision 5 of section 2994-d of this article made by a person connected with the case. The committee shall permit persons connected with the case to present their views to the committee, and to have the option of being accompanied by an advisor when participating in a committee meeting.

(iii) The ethics review committee shall promptly provide the patient, where there is any indication of the patient's ability to comprehend the information; the surrogate; other persons on the surrogate list directly involved in the decision or dispute regarding the patient's care; any parent or guardian of a minor patient directly involved in the decision or dispute regarding the minor patient's care; an attending physician; the hospital; and other persons the committee deems appropriate, with the following:

(A) notice of any pending case consideration concerning the patient, including, for patients, persons on the surrogate list, parents and guardians, information about the ethics review committee's procedures, composition and function; and

(B) the committee's response to the case, including a written statement of the reasons for approving or disapproving the withholding or withdrawal of life-sustaining treatment for decisions considered pursuant to subparagraph (ii) of paragraph (a) of subdivision 5 of section 2994-d of

this article. The committee's response to the case shall be included in the patient's medical record.

(iv) Following ethics review committee consideration of a case concerning the withdrawal or withholding of life-sustaining treatment, treatment shall not be withdrawn or withheld until the persons identified in subparagraph (iii) of this paragraph have been informed of the committee's response to the case.

(c) When an ethics review committee is convened to review decisions regarding hospice care for a patient in a general hospital or residential healthcare facility, the responsibilities of this section shall be carried out by the ethics review committee of the general hospital or residential health care facility, provided that such committee shall invite a representative from hospice to participate.

5.   Access to medical records and information; patient confidentiality. Ethics review committee members and consultants shall have access to medical information and medical records necessary to perform their function under this article. Any such information or records disclosed to committee members, consultants, or others shall be kept confidential except to the extent necessary to accomplish the purposes of this article or as otherwise provided by law.

6.   Ethics review committee confidentiality. Notwithstanding any other provisions of law, the proceedings and records of an ethics review committee shall be kept confidential and shall not be released by committee members, committee consultants, or other persons privy to such proceedings and records; the proceedings and records of an ethics review committee shall not be subject to disclosure or inspection in any manner, including under article 6 of the public officers law or article 31 of the civil practice law and rules; and, no person shall testify as to the proceedings or records of an ethics review committee, nor shall such proceedings and records otherwise be admissible as evidence in any action or proceeding of any kind in any court or before any other tribunal, board, agency or person, except that:

(a) Ethics review committee proceedings and records, in cases where a committee approves or disapproves of the withholding or withdrawal of life-sustaining treatment pursuant to subdivision 5 of section 2994-d of this article, or subdivision 3 of section 2994-e of this article, may be obtained by or released to the department;

(b) Nothing in this subdivision shall prohibit the patient, the surrogate, other persons on the surrogate list, or a parent or guardian of a minor patient from voluntarily disclosing, releasing, or testifying about committee proceedings or records; and

(c) Nothing in this subdivision shall prohibit the Justice Center for the Protection of People With Special Needs or any agency or person within or under contract with the Justice Center who provides protection and advocacy services from requiring any information, report, or record from a hospital in accordance with the provisions of section 558 of the executive law.

New York Consolidated Laws, Public Health Law - PBH § 2972

Dispute Mediation System

1.

    (a) Each hospital shall establish a mediation system for the purpose of mediating disputes regarding the issuance of orders not to resuscitate.

    (b) The dispute mediation system shall be described in writing and adopted by the hospital's governing authority. It may utilize existing hospital resources, such as a patient advocate's office or hospital chaplain's office, or it may utilize a body created specifically for this purpose, but, in the event a dispute involves a patient deemed to lack capacity pursuant to (i) paragraph (b) of subdivision 3 of section 2963 of this article, the system must include a physician eligible to provide a concurring determination pursuant to such subdivision, or a family member or guardian of a person with a mental illness of the same or similar nature, or (ii) paragraph (c) of subdivision 3 of section 2963 of this article, the system must include a physician eligible to provide a concurring determination pursuant to such subdivision, or a family member or guardian of a person with a developmental disability of the same or similar nature.

2.   The dispute mediation system shall be authorized to mediate any dispute, including disputes regarding the determination of the patient's capacity, arising under this article between the patient and an attending physician or the hospital that is caring for the patient and, if the patient is a minor, the patient's parent, or among an attending physician, a parent, non-custodial parent, or legal guardian of a minor patient, any person on the surrogate list, and the hospital that is caring for the patient.

3.   After a dispute regarding the issuance of an order not to resuscitate has been submitted to the dispute mediation system, an order not to resuscitate shall not be issued or shall be revoked and may not be reissued until

    (a) the dispute has been resolved or the system has concluded its effort to resolve the dispute or

    (b) seventy-two hours have elapsed from the time of the submission of the dispute, whichever shall occur first. Persons participating in the dispute mediation system shall be informed of their right to judicial review.

4.   If a dispute between a patient who expressed a decision rejecting cardiopulmonary resuscitation and an attending physician or the hospital that is caring for the patient is submitted to the dispute mediation system, and either:

    (a) the dispute mediation system has concluded its efforts to resolve the dispute, or

(b) seventy-two hours have elapsed from the time of submission without resolution of the dispute, whichever shall occur first, the attending physician shall either:

> (i) promptly issue an order not to resuscitate the patient or issue the order at such time as the conditions, if any, specified in the decision are met, and inform the hospital staff responsible for the patient's care of the order; or

> (ii) promptly arrange for the transfer of the patient to another physician or hospital.

5. Persons appointed pursuant to this section to participate in the dispute mediation system shall not have authority to determine whether a do not resuscitate order shall be issued.

The 9 Provisions of the Nursing Code of Ethics

- **PROVISION 1:** "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person."

- **PROVISION 2:** "The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population."

- **PROVISION 3:** "The nurse promotes, advocates for, and protects the rights, health, and safety of the patient."

- **PROVISION 4:** "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care."

- **PROVISION 5:** "The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth."

- **PROVISION 6:** "The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care [sic]."

- **PROVISION 7:** "The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy."

- **PROVISION 8:** "The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities."

- **PROVISION 9:** "The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy."[71]

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[71]Lauren Katulka,"5-Minute Summary: The ANA Nursing Code of Ethics," *Berxi*, accessed June 29, 2020. https://www.berxi.com/resources/articles/code-of-ethics-for-nurses-summary/.

Definitions

Moral Courage: A nurse's capacity to overcome their fear and stand up for their core values and ethical obligations.[72]

Moral Distress: Moral distress was originally defined as occurring when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.[73] The definition of Moral Distress has been broadened and studied extensively over the years. For the purposes of this education, the original definition is being used.

Moral Resilience: The capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks."[74]

Sacred Covenant: A structured relationship between God and his people, consisting of typical features. A covenant (1) is unilateral, initiated by God alone; (2) creates a structured relationship, or formalizes an already existing relationship, between God and his partners; (3) features binding obligations on the part of God, who commits himself to be God and do certain things, and on the part of the partners, who commit themselves to be faithful and obedient to the covenant terms; and (4) involves covenantal signs or the swearing of oaths. Biblical covenants are the Adamic, Noahic, Abrahamic, old (or Mosaic), Davidic, and new covenants.[75]

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[72] Vicki D. Lachman, "Moral Courage in Action: Case Studies," *MedSurg Nursing*, August 2007:275.

[73] A. Jameton, *Nursing Practice: The Ethical Issues*, (Englewood Cliffs, NJ: Prentice-Hall, 1984:6).

[74] C. H. Rushton, J. Batcheller, & K. Schroeder, "Burnout and resilience among nurses practicing in high-intensity settings," *American Journal of Critical Care,* 24(5) (2015): 412-420.

[75] Gregg R. Allison, *The Baker Compact Dictionary of Theological Terms*, (Grand Rapids, MI: Baker Books, a division of Baker Publishing Group, 2016).

Ethical Principles in Nursing Practice

- **Justice** is fairness. Nurses must be fair when they distribute care, for example, among the patients in the group of patients that they are taking care of. Care must be fairly, justly, and equitably distributed among a group of patients.

- **Beneficence** is doing good and the right thing for the patient.

- **Non-maleficence** is doing no harm, as stated in the historical Hippocratic Oath. Harm can be intentional or unintentional.

- **Accountability** is accepting responsibility for one's own actions. Nurses are accountable for their nursing care and other actions. They must accept all of the professional and personal consequences that can occur as the result of their actions.

- **Fidelity** is keeping one's promises. The nurse must be faithful and true to their professional promises and responsibilities by providing high-quality, safe care in a competent manner.

- **Autonomy** and patient self-determination are upheld when the nurse accepts the client as a unique person who has the innate right to have their own opinions, perspectives, values, and beliefs. Nurses encourage patients to make their own decisions without any judgments or coercion from the nurse. The patient has the right to reject or accept all treatments.

- **Veracity** is being completely truthful with patients; nurses must not withhold the whole truth from clients even when it may lead to patient distress.[76]

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[76] Arlene Burke, "Ethical Practice: NCLEX-RN." *RegisteredNursing.org*. March 11, 2020. https://www.registerednursing.org/nclex/ethical-practice/.

Theological Ethics

The Bible is the soul of theology that guides the body of Christ. The church reads Scripture in order to know God and to be formed unto godliness. Theological method thus involves moving from the text (*sacra pagina*) to truth (*sacra doctrina*) and then from truth to its application in specific contexts of life. Understanding is the operative term, but theologians have turned to a variety of ancillary disciplines for help in reading the Bible, formulating truth, and practicing their faith. Understanding involves grasping the relationship between what the Bible says about God and what we know about the contemporary situation. The ingredients of theological understanding include Scripture, reason, and experience. And because there is a history of Christian understanding, theological method must also attend to church tradition. The presence of certain "helping" disciplines, however, often inclines theologians to give more weight to one of these factors than the others.[77]

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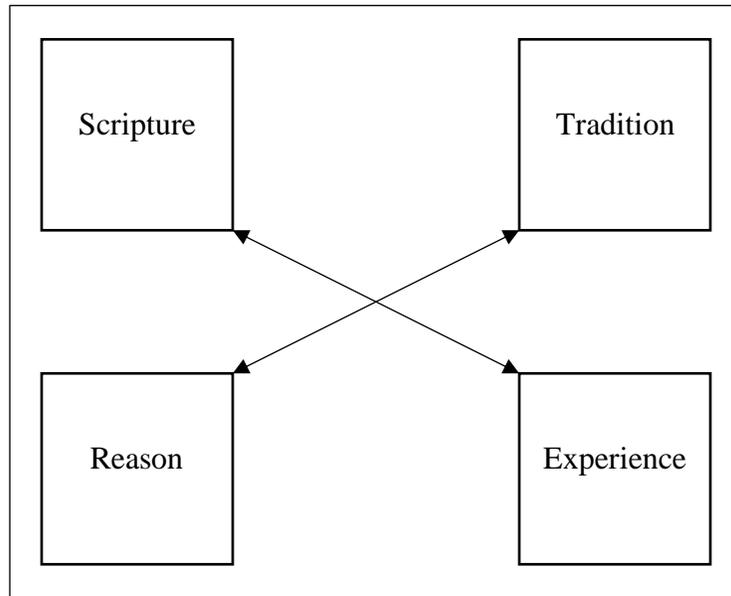
[77], William A. Dyrness, Kärkkäinen Veli-Matti, Juan F. Martinez, and Simon Chan. *Global Dictionary of Theology: a Resource for the Worldwide Church*. Downers Grove, IL: IVP Academic, 2008.

A Case Study

Moral Courage with a Dying Patient

Mr. T. is an 82-year-old widower who has been a patient on your unit several times over the past 5 years. His congestive heart failure, CHF, COPD, and diabetes have taken a toll on his body. He now needs oxygen 24 hours a day and still has dyspnea and tachycardia at rest. On admission, his ejection fraction is less than 20%, EKG shows a QRS interval of greater than 0.13 seconds, and his functional class is IV on NYHA assessment. He has remained symptomatic despite maximum medical management with a vasodilator and diuretics. He tells you, "This is my last trip; I am glad I have made peace with my family and God. Nurse, I am ready to die." You ask about an advance directive, and he tells you his son knows that he wants no heroics, but they just have never gotten around to filling out the form. When the son arrives, you suggest that he speak with the social worker to complete the advance directive, and he agrees reluctantly. You page the physician to discuss DNR status with the son. Unfortunately, Mr. T. experiences cardiac arrest before the discussion occurs, and you watch helplessly as members of the Code Blue Team perform resuscitation. Mr. T. is now on a ventilator, and the son has dissolved into tears with cries of, "Do not let him die!" What is the action the nurse needs to take?

It is the ethical obligation of this nurse to support the self-determination of this patient. This patient had capacity when he voiced, "no heroics," and the expectation that his son, as his surrogate decision maker, would honor his expressed wishes. Mr. T. met the criteria for hospice referral prior to hospitalization, but even more so now that he has a history of cardiac arrest (National Hospice Organization, 1996). The attending physician is not discussing the facts of the case with the son and has never brought up the topic of hospice. The Code for Ethics for Nurses (the Code) (American Nurses Association [ANA], 2001, p. 9) provides the following guidance for the nurse: "The nurse supports the patient's self-determination by participating in discussions with surrogates, providing guidance and referral to other resources as necessary, and identifying and addressing problems in the decision-making process."

The nurse knows the son will need help in letting go of his father and asks if he would like her to call his sister and pastor. The nurse also musters the courage to start a conversation with the physician and discovers that Mr. T. has been his patient for 20 years. Though both physician and son initially are defensive, the nurse's assertiveness and perseverance get results. Mr. T. is removed from the ventilator 24 hours later. He dies peacefully in the presence of his family and physician.[78]

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[78] Lachman, *Moral Courage in Action: Case Studies*, 275.

Appendix C

Code Lavender Policy

TITLE: Code Lavender	NUMBER: 3031	REVISED DATE: June 2021	OWNER: Director of Pastoral Care and Volunteer Services
CROSS REFERENCES:			

PURPOSE OF POLICY

The purpose of the policy is to outline the Code Lavender program, which will help to improve health, reduce stress, and build resilience in the patient care team. The policy will outline the response during a stressful event or loss while in the workplace.

SCOPE

The policy applies to clinical staff at Ellis Medicine.

DEFINITIONS

Code Lavender Team: Consists of a team of responders who are called when an employee has reached an emotional limit. The response may consist of pastoral care, integrative therapy practitioners, mental health professionals, nutrition services, and the employee assistance program.

Lavender Room: A room at the Ellis Hospital campus and Bellevue campus that provides an area for nurses and clinical staff to decompress and relax during stressful times.

PROCEDURES

Lavender Room

The Lavender Room will be a room intended for relaxation and reflection during stressful times. The room is not intended to be used as a lunchroom.

When social distancing restrictions are in place, the room is limited to two attendees at a time, and social distancing and masking must be followed if two people are in attendance.

The room is available 24 hours a day.

The room can be utilized by all clinical staff.

The room will include the following:

Soothing music and sounds

Dim, non-glare lighting

Aromatherapy

Comfortable seating

Supportive Services will also be offered in this room at scheduled times when available, which include:

Integrative Therapy Practitioners

Reiki Therapy

Healing Touch

Therapeutic Touch

Meditation

Pastoral Care

Code Lavender Activation

Any teammate may initiate Code Lavender when departmental or individual teammate stress is a concern. Events that may trigger a Code Lavender request include:

workplace violence

multiple or difficult deaths

a teammate experiencing a personal crisis such as a death in the family or a family member requiring extra care

The Code Lavender is initiated by calling the nurse manager during normal business hours or the operator to notify the nursing supervisor at each campus to respond and evaluate a need for support.

The nurse manager/supervisor will conduct a Code Lavender assessment to determine the nature and level of the caller's stress and needs at the time of the call utilizing the Code Lavender Worksheet; see Exhibit A.

Based on the assessment, resources (people and tools) will be deployed to meet the caller's needs, which may include further connection to a local resource.

The Code Lavender response includes:

Pastoral Care

Nutrition Services: provides water and snacks

Nursing Leadership: nurse manager, director, or supervisor during off shift

Referral to Employee Assistance Program

Referral to Human Resources

Time away to reflect in Lavender Room

REFERENCES

Stone, S.B. (2018). Code lavender: A tool for staff support. Nursing 2018. 15–17.

Tsai, S. (2017). Code lavender: Healthcare providers caring for themselves. Retrieved from www.healthcarerecruiting.com/blog/3983/code-lavender-healthcare-providers-caring-for-themselves.html.

Exhibit A: Code Lavender Worksheet

ORIGINAL IMPLEMENTATION DATE: June 7, 2021

REVIEW DATE: 6/23

REVISED DATE:

REVIEWED BY:

Code Lavender Committee

Sr Director of Nursing

VP of Human Resources

Director of Professional Practice

Quality Services

Exhibit A: Code Lavender Worksheet

(please print neatly)

Today's Date:	Time:

Caller's Information	
Name of Caller:	Dept/Unit/Floor:
Job/Role/Title:	Phone:

INITIAL REQUEST/REFERRAL
For whom are you requesting a Code Lavender?
What's the situation? Why is a Code Lavender needed at this time?
Request Timeframe: ☐ Now/ASAP   ☐ Scheduled:

Is your unit/dept. leadership already aware of the request? ☐ Yes ☐ No	Who?

Point(s) of Contact	
<u>Primary</u> Point of Contact:	Phone:
Job/Role/Title:	Email/Other:
Best Time to Contact/Comments:	
Additional Point of Contact:	Phone:
Job/Role/Title:	Email/Other:
Best Time to Contact/Comments	

Notification/Coordination		
Debrief requested? ☐ Yes ☐ No	Requested by:	Phone:
Notes:		
Chaplain has notified: ☐ Chaplain On-Call ☐ Unit Chaplain		
Notes:		

DETAILED DISCUSSION
What else would it be helpful for us to know?
Specifically, how are you expecting the Code Lavender to help staff?

Are there specific interventions that you want or don't want to see as part of the Code Lavender?

	Planning						
	Interventions	**Body**	**Mind**	**Spirit**	**Notes:**		**Used?**
1	**Presence of Chaplain**						
2	**Notification to Nurse manager if off shift**						
3	**Time away in Code Lavender Room**						
4	**EAP referral**						
5	**Notification of HR**						
6							
7							
8							

How will staff know about the Code Lavender? ☐ **Will be visible** ☐ **Huddle** ☐ **Other (explain below)**

DELIVERY & EVALUATION

Describe what you did—especially how you adapted the interventions you used to fit the people/situation or environment. What worked well? What might you do differently?

Supplies have been collected, put away? ☐ **Yes**	**Notes:**
Feedback Received Attach separate sheet(s) if necessary	

Return form to Director of Pastoral Care