Preventive Ethics in the Intensive Care Unit
Elizabeth Gingell Epstein, RN, PhD

Preventive ethics proposes that ethical conflict is largely predictable and can be avoided with proactive interventions aimed at the organization, unit, and individual levels. The goals of preventive ethics are to use a proactive approach to identify common triggers of ethical conflict and to address these triggers before they contribute to conflict. Therefore, preventive ethics represents a dramatic shift from the traditional ethics approach, which uses a case-by-case approach—reacting to ethically challenging patient situations as they arise in the clinical setting or when a consultation is requested.

Two major problems exist with the traditional, reactive approaches to ethical issues in clinical settings, particularly critical care. First, addressing clinical situations in crisis is time-consuming and problematic, as communication and collaboration are usually compromised and mutually agreeable resolutions are difficult to achieve. Second, the traditional approach does not address systems issues, such as hierarchies and unit processes, that profoundly influence decision making and the trajectory of care.

Preventive ethics recognizes these issues and can be useful in the critical care setting, where environmental and clinical complexities often lead to ethical controversies. A commonly held assumption is that improvements in shared decision making and information exchange can yield appropriate and agreed-upon courses of treatment. However, this aspect of decision making is only the “tip of the iceberg,” and the more significant and influential portion of the situation, the organizational and environmental climate, lies beneath the surface. This article uses a case-based approach to introduce a process for preventive ethics in the intensive care unit (ICU) and highlights the importance of the role of critical care nurses in this process.

The Case of David B
David B was a healthy 32-year-old man who sustained a serious head injury in a construction site accident. He was admitted, intubated and unconscious, to the neurology ICU. During the 6 weeks of his admission, he never regained consciousness. His wife, Marlene, initially visited in the evenings, when she was able to find a babysitter and arrange for transportation to and from the hospital. She spoke with an attending physician on only 1 occasion during the first 3 weeks of David’s stay. Marlene was reluctant to discuss any limitation in treatment or to consider any outcome other than full recovery, because her pastor had told her to “expect a miracle.” At the end of the first week in the ICU, 3 of the 4 neurology attending physicians agreed that David’s condition was irreversible and that further aggressive treatment could (and should) be withheld. The fourth, however, cogently argued that it was “too soon to tell.”

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Nurses caring for David recognized subtle signs of deterioration and agreed that David was unlikely to recover. With each change in the attending or fellow physician, however, the treatment plan seemed to change, which frustrated the nursing staff and several residents. Marlene grew increasingly confused and frustrated as well. Family meetings were suggested in the fourth week of David’s stay, after several nurses and residents noted that Marlene was angry and did not appear to understand David’s condition fully. During week 5, the first (and only) family meeting was held. By the end of the meeting, Marlene understood David’s poor prognosis, but the plan for care continued to include aggressive treatment, as Marlene felt certain that taking David off the ventilator was the same as killing him. David’s condition deteriorated significantly in week 6, and he died despite aggressive efforts at resuscitation, at the insistence of his wife.

These types of clinical scenarios occur repeatedly in the critical care setting. They are ethically challenging and can lead to moral distress, withdrawal from the ethical aspects of professional practice, and professional burnout. Furthermore, in times of ethical conflict, high-quality, collaborative care and care in the best interest of the patient are likely to be compromised. However, the very fact that these situations are so familiar provides important clues for preventing similar situations in the future. A preventive ethics approach calls on the health care team to recognize these familiarities and to intervene early so as to avoid ethical conflict later.

Apart from a program in the Veterans Administration, which provides support and infrastructure for integrated ethics, no clearly defined processes for establishing a unit- or institution-based preventive ethics program are available for the typical hospital setting. The field is in its infancy. Establishing such a program will involve a systematic approach to identifying triggers and designing interventions to address those triggers as well as a mechanism for routine surveillance and a process for evaluation of the program. This article provides a series of points to consider and possible ways to proceed in establishing a preventive ethics program. This approach is not meant to be a prescriptive method for establishing a preventive ethics program, but rather it is a launching point for critical thinking and innovation about the issue of ethical conflict, which continues to confound and deeply trouble health care providers.

Assessment of Commonly Occurring Triggers for Ethical Conflict

Currently, the preventive ethics literature uses a broad ethical lens, targeting system problems rather than individual patients, as with the traditional ethics approach. A leader in the preventive ethics field, the Veterans Administration defines preventive ethics as “activities performed by an individual or group on behalf of a health care organization to identify, prioritize, and address systemic ethics issues.” In fact, however, the literature suggests that common triggers occur at several levels. Three levels appear to be most significant: patient and family, unit, and system. The core problem of triggers at each level is that they have the potential to undermine the provider-patient/family or surrogate relationships, which are foundational for ethical medical and nursing practice. Thus, keeping an eye toward issues that alienate or undermine the provider-patient/family or surrogate relationships is helpful for identifying triggers.

Patient/family/surrogate-level triggers depend on the individual case. They are, on one hand, unique to the case and, on the other, commonly recurring. For example, Marlene’s personal perceptions and beliefs in her expectation of a miracle were unique to her. However, the broader issue of religious/spiritual beliefs is commonly encountered by clinicians. Another patient- and family-level trigger was Marlene’s infrequent visits, which led to infrequent provider updates and a lack of exposure to David’s deteriorating condition. Other examples of patient- and family-level triggers are as follows:

- Vulnerability (elderly, very young, non–English-speaking, incapacitated)
- Lack of social support
- End-of-life situation
- Disagreement with health care providers
- Unrealistic expectations of implicit assumptions that treatment will be effective

Unit- and system-level triggers are independent of the individual patient. At the system level, triggers are hospital-wide problems that affect the entire health care setting, such as hospital policies that conflict with family needs or are unclear, procedures for maintaining patient or staff confidentiality, or inadequate resources. In David’s case, for example, a restrictive, hospital-wide visitation policy contributed to the ethical dilemma. Unit-level triggers are problems that
arise repeatedly within a particular unit. Examples include the following:15,16,20

- Lack of team consensus or conflict within the team
- Inconsistent providers
- Strong hierarchical (power) structures
- Ineffective shift report or handoff procedures
- Late or absent family meetings
- False hope or avoidance of difficult discussions

In David’s case, the large turnover in providers (nurses and physicians) caring for David was a unit-level trigger. Provider inconsistency led to an inability of the nursing and medical staffs to establish a good provider-family relationship with Marlene. In turn, a mutual understanding of the medical and family perspectives was unattainable, and shared decision making was seriously impaired.

**Intervention Planning**

Once common triggers are identified, specific interventions to address them can be planned. Some effort has been taken to tie preventive ethics with quality initiatives, as both quality and preventive ethics address recurring issues in the health care setting.14,15 A systematic review of past ethically challenging situations will begin to shed light on common triggers of ethical conflict. These triggers can then be categorized into the 3 levels (patient and family, unit, and system). The critical incident technique (a review of provider narratives of ethically challenging situations) was used with good results in a recent study of early indicators and risk factors for ethical conflict by Pavlish et al.16,21 This technique involves identifying a type of event (eg, situations of conflict near the end of life), collecting narratives of that type of event, and evaluating the common themes within those narratives. This technique can be helpful in deciphering how the event evolved over time, who was involved, and what elements might be commonly found within this type of event.

For example, in the neurology ICU where David had been a patient, narratives were collected from staff involved in incidents of conflicts near the end of life. Suppose that David’s nurses noted, in their narratives, that David was young, that his wife had been expecting a miracle, that she had difficulties with transportation and child care, and that apparent signs of deterioration had been ignored. The physician’s narratives might have addressed the issue that David’s neurological injuries were very serious, but that he was young and there was concern about discontinuing treatment too early. They also may have noted a difference of opinion within the team and that family meetings were rare. These narratives would be combined with other narratives from previous similar events to more clearly identify common themes (triggers). Suppose that late initiation of family meetings was a common finding among the narratives and was believed to be a trigger for conflict. A unit-level intervention to schedule weekly meetings, the first being within 48 hours of admission, could be tested over a period of months. Evaluating the outcomes could involve another critical incident assessment, this time focusing on end-of-life situations in which regular family meetings had been held. Analysis of these types of narratives could help identify whether regular family meetings reduce the likelihood of conflict.

**Patient- and Family-Level Interventions**

At the patient and family level, a cadre of interventions can be tailored to specific patient situations, using the list of identified triggers as targets. Many interventions can be readily and directly implemented (see Table 1 for examples). For example, suppose that infrequent family visits are an identified common trigger. A rapidly implementable intervention could include a simple assessment of the reasons for the infrequent visits. In David’s case, if Marlene had stated that she was unable to visit because of lack of reliable transportation or babysitting, a rapidly implementable intervention would have been to provide taxi vouchers or to introduce Marlene to the babysitting service that is already available in the hospital. The issue may be simply that services exist, but Marlene was unaware of them. The brief conversation necessary to understand Marlene’s predicament could make all the difference in meeting her needs. If these services are not available already, the lack of services may be an identified shortcoming, moving the issue up to the level of the unit or system. Generally, interventions at this level are aimed at strengthening the provider-patient/family relationship, exploring patient and family beliefs, investigating cultural practices, and improving the consistency of providers at the bedside.
Table 1: Examples of Potential Patient- and Family-Level Interventions

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<tr>
<th>Trigger</th>
<th>Possible Interventions</th>
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<tr>
<td>Unrealistic expectations or implicit assumptions that treatment will be effective</td>
<td>Explore the origins of these expectations with the patient and family</td>
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<td>Engage in frequent, consistent dialogue with the patient and family</td>
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<tr>
<td>Religious beliefs that interfere with medical reality</td>
<td>Explore patient and family beliefs and document important aspects of their beliefs</td>
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<td>Ask to meet their religious leader to better understand the foundations of patient and family beliefs</td>
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<td>Enlist the help of hospital chaplaincy</td>
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<td>Find a member of the health care team who has similar beliefs and who is willing to care for the patient and family on a consistent basis</td>
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<td>Consider an in-depth assessment of patient and family spiritual beliefs using an instrument such as the Spiritual Assessment Tool24</td>
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<td>Infrequent visits or contact with providers</td>
<td>Investigate reasons for infrequent family visits: Does it cause anxiety to see their loved one so sick? Is there a problem with transportation?</td>
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<td>Address the underlying cause: Provide taxi vouchers if a transportation problem exists, help family members see their loved one in the bed rather than all the equipment</td>
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<td>Teach the family about the equipment: Explain the alarms; reassure the family that those caring for their loved one understand the situation and are providing high-quality care</td>
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<td>Lack of social support</td>
<td>Identify a small cohort of nurses who can provide consistent care for the patient; this familiarity may serve as a type of support for those who lack family or other social support</td>
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<td>Institute a point-contact system: point contacts can be either a particular family member to whom updates are provided (rather than to many family members) or a particular provider (nurse, physician, nurse practitioner, clinical nurse specialist, social worker, chaplain, care coordinator) who can consistently be able to take questions from the family; this point contact need not always take care of the patient or be able to answer all questions, but rather, this person serves as a contact who can more easily identify providers who can answer the family’s questions</td>
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<tr>
<td>Cultural beliefs that are unfamiliar to providers</td>
<td>Ask the patient or family to describe their culture: What should the team know about their culture? What would help the family?</td>
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<td></td>
<td>Research the culture</td>
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<td></td>
<td>Draw upon outside resources</td>
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<td>DiversityRx: <a href="http://www.diversityrx.org">http://www.diversityrx.org</a></td>
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<td>Transcultural Nursing Society: <a href="http://www.tcns.org">http://www.tcns.org</a></td>
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<td></td>
<td>National Coalition for LGBT Health: <a href="http://lgbthealth.webolutionary.com/">http://lgbthealth.webolutionary.com/</a> content/resources</td>
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Unit-Level Interventions
Most changes at the unit level occur slowly and in small increments. Interventions at this level largely involve outlining potential ideas for addressing problems, rather than fixing the problem in one large effort. These interventions bring attention to the issue and set the stage for changes in practice that will occur over time. Knowledge of the unit’s barriers and facilitators to changes in routines and procedures, as well as available resources (human and financial), would be helpful in recognizing potential pitfalls.
and bottlenecks as well as avenues for substantive change. Interventions need not be elaborate or complicated. In fact, elaborate interventions that dramatically change current practice are difficult to implement and to sustain. Instead, simple, workable interventions that fit easily into current practice, that have interprofessional support, and that do not require a significant budget are more sustainable over the long term and therefore more likely to be successful.

As an example of intervention planning, suppose that after a systematic assessment of Unit A’s triggers, identified unit-level triggers included late initiation of family meetings, inconsistent providers, and frequent lack of consensus among team members. One trigger, late initiation of family meetings, is chosen for intervention planning. The preventive ethics team (a small group of nurses and physicians from Unit A as well as a social worker and a quality officer from the institution) gathers information about current unit policies and guidelines regarding family meetings. The team investigates how other units implement family meetings and solicits several providers’ opinions about the current process and usefulness of family meetings. The team members draw on this information and other resources, such as components of a family meeting toolkit22 or ideas from an intensive communication intervention,23 to create a plan for Unit A. Once this intervention is planned, the preventive ethics team begins to plan possible interventions for other triggers, such as inconsistent providers. In taking these steps, the group constructs a table or algorithm that outlines triggers and potential interventions to be addressed (see Table 2 for examples). With unit-level intervention planning, much work remains. Focused efforts to change practice are needed. This work is beyond the scope of the preventive ethics team and is likely to require new teams, task forces, or quality initiatives to change unit practice.

System-Level Interventions
System-level interventions require input and collaboration outside the boundaries of the unit and are beyond the scope of this discussion (see Fox et al1 for a detailed outline for addressing systematic ethics issues). The focus here is on potential interventions for patient/family-level and unit-level triggers.

This 3-level approach to preventive ethics is unique, and no standardized or validated interventions targeting preventive ethics are currently available. However, a growing body of resources1,17–19,22,23–26 which can guide both the design and implementation of workable, effective interventions yet leave space for creativity and catering to individual settings, is available.

Routine Surveillance
The preventive ethics plan now includes the list of identified triggers on 3 levels and possible interventions to address those triggers. To identify these triggers on a case-by-case basis, a regular process for surveillance of the patient population is necessary. This process could be heavily influenced and managed by nursing staff and should be tailored to the daily function and routines of the unit. A hypothetical procedure is provided as an example.

<table>
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<th>Trigger</th>
<th>Possible Intervention Plan</th>
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<td>Late initiation of family meetings</td>
<td>Create a list of patients for whom early family meetings would be helpful (ie, patients who remain critically ill 48 hours after admission to the intensive care unit)</td>
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<td>Construct a procedure for initiating an early team meeting to discuss current plan, followed by initial and regularly scheduled follow-up family meetings</td>
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<td>Inconsistent providers</td>
<td>Identify a small cohort of nurses willing to provide care for at-risk patients on a consistent basis</td>
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<td>Bring facts to rounds: Count the number of nurses and physicians who have cared for the patient over the past week</td>
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<tr>
<td>Lack of consensus</td>
<td>Construct a process for scheduling team meetings to discuss different perspectives about care of patients with complex problems</td>
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The preventive ethics team on Unit A has identified the daily interprofessional rounds routine as a logical point for routine surveillance. On Unit A, rounds are conducted every morning at each patient’s bedside. Attendees include the charge and bedside nurses; attending, fellow, and resident physicians; dietitian; pharmacist; social worker; and other disciplines as needed. In addition, although family members are not often present and most patients are critically ill and unable to participate fully in discussions, patients and families are encouraged to attend and provide feedback and input as they are able.

The preventive ethics team creates a series of questions aimed at identifying common triggers as part of the surveillance procedure (Table 3). Using the tables of triggers and potential interventions, the group creates an algorithm for implementation of interventions that will be activated if a trigger is identified for a patient. The usefulness of the questions and the feasibility of the interventions are examined during a set trial period. Medical and nursing feedback is solicited, and revisions to the process are made. After another round of testing, the preventive ethics process for routine surveillance is implemented across the unit.

Creating an Evaluation Strategy
Evaluating the effectiveness of interventions is a critical but challenging aspect of the preventive ethics process. The recommendations of a quality officer within the institution may be very helpful. Several aspects of the process must be evaluated. First, the sustainability of the preventive ethics process itself must be reviewed. Who can take on the project most easily (charge nurses, preventive ethics working group), and are they willing to continue the program? Is there a quality team on the unit or in the institution that would be able to take on the evaluation aspect?

Second, the feasibility of the interventions must be reviewed. Which interventions are easily implemented? Which are more difficult? What next steps should be taken for those changes that require more work (unit and system level)?

Third, the effectiveness of the patient- and family-level interventions must be evaluated. The routine surveillance process itself can be useful for this purpose. For example, in David’s case, an intervention to address the trigger “infrequency of family visits” was implemented. At this institution, taxi vouchers were unavailable. Thus, the interventions implemented included designating a core team of nurses to provide care for David and a daily phone call to Marlene from the bedside nurse or physician to discuss David’s condition and the treatment plan and to answer any questions Marlene may have had. After 4 days of this intervention, the routine surveillance process indicated that Marlene was now being updated daily by a member of the team. Two nurses from the core nursing team had begun to gain her trust and were beginning to understand her situation more clearly. These nurses had lengthy, meaningful conversations with Marlene about how she and David had been high school sweethearts and her fears of how David had been the sole breadwinner for the family and how she would raise their daughter without him (which led to the involvement of a social worker to help her navigate potential options for financial and grief support). Using this gauge, the intervention to address Marlene’s infrequent visits and the threat that had on the provider-patient/family relationship appears to have been successful.

Fourth, an evaluation of whether patients and families are satisfied with the care that is given needs to be made. Multiple surveys of patient and family satisfaction are available. Additional questions targeting triggers could be added, but because of the complexity of care in the ICU setting, survey results would not reflect the success of the preventive ethics process specifically. Rather, these surveys would provide a more general view of patient and family satisfaction with care and may be useful for highlighting areas that could be addressed by the preventive ethics process.

Finally, although the overall goal of the process is to reduce or avoid ethical conflict, assessing reduction in ethical conflict is challenging. One method would be to track the frequency of positive answers to the final question in the routine surveillance process (“Is this patient’s situation ethically challenging at present?”) and to determine whether this frequency decreases over time. Another method might be to conduct periodic brief surveys of staff to determine whether, in their view, there are ethically challenging cases presently in the unit and whether those cases are being successfully intervened by the preventive ethics program. If system- or unit-level triggers are addressed, improvements in the unit environment may be detected. A survey, similar to Olson’s Hospital
Table 3: Sample Questions to Trigger Preventive Ethics Intervention to Reduce Conflict in the Intensive Care Unit

1. Is the patient able to contribute to decisions about his or her care?
2. Is the patient still in critical condition 48 hours after admission?
3. Has the patient’s family visited in the last 48 hours?
4. Are the patient and family non-English speaking, or are they members of a cultural group that is unfamiliar to most providers on this unit?
5. Has the family been updated by the team in the past 24 hours?
6. Has today’s bedside nurse cared for this patient before?
7. Has the bedside nurse established rapport with this patient and family?
8. How many different nurses have cared for this patient in the past week?
9. Has the family stated strong religious beliefs that could potentially conflict with medical treatment?
10. Is there consensus among the team members with regard to this patient’s prognosis and treatment plan?
11. Are there any unit routines or procedures that negatively affect this patient’s care?
12. Is this patient’s situation ethically challenging at present?

Ethical Climate Survey,27 was designed to assess staff perceptions of collaboration, decision making, and ethical practices within a unit. This instrument has been used in research studies with physicians and nurses9,27,28 but has not been used in quality initiatives or before and after an intervention.

Critical Nature of the Nursing Role in the Preventive Ethics Plan

To some degree, critical care nurses are embarking on new territory—not just for nursing but for health care overall. The field of preventive ethics is in its infancy. However, addressing triggers of ethical conflict early is a path worth taking. Because of their consistent presence in the unit and at the bedside, nurses can play a central role in preventive ethics. No other profession has the depth of knowledge of unit function, capability, and potential as the nursing staff. Identifying unit-level triggers as well as interventions to improve them, to change unit protocol, or to use resources in a different way requires this kind of intricate knowledge. Likewise, no other group has greater investment in the unit’s success and quality. A dedicated nursing staff is likely to be quite motivated to see a preventive ethics plan succeed for the good of the unit.

Nurses have the unique privilege of having an intimate and profound understanding of patient and family needs and of being able to recognize patient- and family-level triggers. Nurses are not often present at the decision-making table but often have important knowledge to contribute. The feeling of powerlessness in critical clinical situations often causes moral distress (moral distress is common among physicians as well),3 which, in turn, can lead to a numbing of moral sensitivity, retreat from ethically challenging clinical situations, burnout, and intentions toward leaving a position or the profession altogether.7,9,10 At a time when the nursing voice is needed more than ever in ethically challenging situations, many nurses find themselves lacking confidence in their ability to communicate using ethics language. A preventive ethics plan uses the skills of nurses as well as practical approaches to complex issues and, most importantly, brings nurses to the table.

REFERENCES


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