Belonging at the Table: Moving Beyond Inclusion in Ethics Discussions

Pageen Manolis Small*

Keywords: Inclusion, nurse, healthcare ethics, discussion, consult, interdisciplinary communication

"Should we call ethics?" I don't remember if it was the day nurse or myself, the night nurse, who articulated the question. I do remember that we both thought it was a good idea. We had been "handing off" the same patient for the past several days as each of us worked several consecutive 12-hour shifts. "Jordan" was critically ill and wasn't getting better. My fellow bedside nurse and I shared concerns that Jordan's parents had unrealistic expectations regarding possible outcomes and that Jordan was unnecessarily suffering. During one of our handoffs, the critical care resident came up to us to check in on how Jordan had done overnight, and one of us posed the question to him: "Should we call ethics?" We expressed our concerns about unattainable goals and our discomfort with the amount of suffering Jordan was enduring, and our participation in prolonging Jordan's suffering. The resident did not agree that an ethics consultation was warranted. He listened to our concerns and talked through his reasoning. I understood his point but wasn't sure I agreed. Yet, neither the other nurse nor I called ethics ourselves, thinking that the physician's decision was the determining factor.

That experience, and my surrounding uncertainty, was one of the events that led me to become an ethicist several years later. Currently, I work both as a nurse and as a clinical ethicist. My roles overlap and inform each other. I spend a lot of time learning about and addressing barriers to ethics consultations. Many staff express uncertainty about when a consult is needed, and many non-physician staff think that a physician should decide whether to call for a consult. Some staff members are even unaware that any member of a patient's healthcare team can request a consult. Despite often being earlier identifiers of ethical issues, research shows that nurses often do not address ethical issues. When they do address issues, they may not fully explore the ethical issue and all its facets.[1] Nurses also often face organizational and structural barriers to addressing and resolving ethical issues.[2]

* Pageen Manolis Small, BSN, MS

Ethics consultations should be a safe moral space where ethical issues are robustly discussed and fully explored.[3] An important part of ethics work is overcoming barriers to the discussion and fostering a sense of belonging at ethics consultations for all relevant participants. We may often talk about who to include in an ethics consultation, which is a necessary discussion to ensure key people are present in the discussion. Inclusion is important. Healthcare ethics consultation teams are obligated to ensure access for healthcare providers, patients, and any other members of patients' healthcare team.[4] A broad goal of ethics consultations is to aid in the resolution of ethical conflicts and concerns. This involves understanding diverse perspectives and bringing these perspectives together in a respectful dialogue that seeks to understand different views, enlighten the understanding, and work toward a resolution. Ethics consultants and committee members have diverse backgrounds and experience; yet, they may struggle to fully include a similar diversity level from patient care teams. A while back, an ethics consultant colleague of mine was scheduling a consult for a patient. The patient's primary inpatient nurse had requested the consult. One of the ethics team members strongly expressed that the attending physician needed to be at the consultation, but not as much effort was put into enabling the requesting nurse or another direct care nurse who knew the patient well to participate.

Physicians are the primary requesters of ethics consultations even though other staff, patients, and family members also identify ethical concerns. Certainly, multidisciplinary discussion among the patient care team precipitates many requests. The culture of the physician as a leader lends itself to the physician being the consult requester. However, this tendency is potentially problematic as the requester is then deemed the "point person" and is the first to share the narrative from their perspective, leading to an anchoring bias. Ethics consultants must be aware of their biases and actively seek to overcome them. Another colleague of mine once shared a case prompted by a question from the nurses, but the formal request came from the attending physician. The consult was via telephone and somewhat informal due to the immediacy of the issue. As the ethics consultant, my colleague spoke only to the attending physician. During the case review, another colleague asked what the nurses thought about the outcome. The consultant admitted that he had not talked with them as part of the process or followed up regarding the outcome and suggested he would strive for better follow up in the future.

Yet, inclusion by itself is not enough. We must go beyond simply having diverse representation within consults. All participants must know that their insights and perspectives matter and impact the decision. Ethics consultants must go beyond inclusion to generate a sense of belonging. While inclusion is inviting someone to speak, belonging generates a sense of value and acceptance of someone's voice. Everyone involved should feel empowered to speak and share their thoughts and ideas. Yet, if those ideas are not valued, discussed, and fully considered, empowerment will disintegrate, and inclusion will have little substantive value. These important voices will be lost, and we will have less depth and robustness to our discussion. Patients, families, and staff will suffer from this inability to reach the best outcomes.

Belonging fosters acceptance and valuing of others' ideas and perspectives. Having thorough insight and understanding of the ethical issue at hand helps ensure the best decision is made for the patient. Ensuring that the participants feel valued and understand the decision also promotes support of the decision, could reduce the risk of moral distress, and fosters better interdisciplinary communication. Another colleague recently shared a case that a nurse called. Several nurses attended the consult. During the case review, someone asked what the nurses thought about the outcome. There was a pause, then the consultant carefully replied, "They appreciated that their voices were heard." I wondered whether the nurses felt more than heard and whether they supported the decision made. Did these nurses find the consultation to be successful? Would they request an ethics consultation again?

Participants in ethics consults should understand the rationales used in decision-making. The ethics consultant must synthesize the various perspectives and mediate reasonable recommendations. They must also provide discussion and education to promote understanding of the issue and the ethical recommendation. All parties may not agree, but we can work towards better understanding and acceptance. An important outcome of ethics consultation is the satisfaction of participants.[5] Feeling like one belonged in the discussion and that one's insights and comments matter promotes satisfaction and increases the chance that ethics consultation services are evaluated to be useful and likely to be sought again. Agreeing that the conflict is resolved can reduce moral distress and enhance communication going forward.

Sometimes, I think about Jordan, the ethical concerns myself and my fellow nurses had about Jordan's care and our associated moral distress. Jordan died peacefully a few weeks after my nursing colleague and I brought up our ethical concerns to the resident. Some might say it was the best outcome we could have hoped for given the circumstances and that an ethics consult may not have changed the outcome: Jordan would still have died, perhaps a little sooner, probably just as peacefully. But an ethics consult could have helped the healthcare team talk through and understand options. It could have helped the staff navigate our own moral distress. It could have facilitated interdisciplinary communication and understanding. Those are important outcomes, too, and we need to be careful not to overlook them.

[1] Pavlish, Carol et al. "Nursing priorities, actions, and regrets for ethical situations in clinical practice." Journal of nursing scholarship: an official publication of Sigma Theta Tau International Honor Society of Nursing vol. 43,4 (2011): 385-95. doi:10.1111/j.1547-5069.2011.01422.x

[2] Haahr, Anita et al. "Nurses experiences of ethical dilemmas: A review." Nursing Ethics vol27,1 (2020): 258-272. doi:10.1177/0969733019832941

[3] Walker, Margaret Urban. "Keeping moral space open. New images of ethics consulting." The Hastings Center report vol. 23,2 (1993): 33-40.

[4] American Society for Bioethics and Humanities (ASBH). *Core Competencies for Healthcare Ethics Consultation, 2nd Edition*. Chicago, American Society for Bioethics and Humanities, 2011.

[5] ASBH. *Core Competencies*.