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Experiential ethics education: one successful model of ethics education for undergraduate nursing students in the United States

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ABSTRACT
Lachman, Grace and Gaylord[1] have argued that for bioethics education for undergraduate nursing students, a preferred combination of instruction involves a clinically-based nurse with ethics training and a philosophically-based ethicist with clinical training. At the University of Pennsylvania School of Nursing, undergraduate nursing ethics instruction takes this form. The course director is a philosopher with extensive clinical experience in ethics. The course utilises four distinct forms of nursing clinical inputs to educate undergraduate nursing students using a unique combination of didactic and experiential learning exercises to simulate real ethics cases. This paper describes how the course was developed and refined over the past several years and suggests several ideas for improvements in nursing ethics education at an undergraduate level.

Introduction

Ethics education in the health professions frequently involves the use of case studies to elucidate key ethical principles in action and application. Traditional presentation and discussion of cases allows retrospective consideration of ethical decision making. The teaching methods in the course presented in this paper take a different approach to ethics cases and learning. Using a form of experiential learning, called simulation, borrowed from the instructor's experience in mediation training,[2] cases are designed for live role-play during class and involve five distinct activities: 1) two or more students play the role of ethics consultants; 2) a number of students play the roles of patients, surrogates, family members, and clinicians who are either in ethical conflict or uncertainty; 3) two or more evaluators watch the evolving role-play and note process, substance, and interpersonal qualities for later comment, assessment, and group discussion; 4) the remaining students in the audience also participate in the evaluation

and grasp how the ethical principles and substance of a particular topic work; and 5) instructor-led post hoc evaluation of the case in light of ethical substance from the readings and ethics literature.

Table One and Table Two, respectively, list the issues covered and provide the cases used during the semester.

Ethical framework

The instructor has used the second and third editions of the textbook *Introduction to Clinical Ethics*[3] since the course's initial inception and evolution. The course currently uses the third edition of this textbook, as well as a companion textbook produced exclusively for nurses.[4] The ethical framework articulated in *Introduction to Clinical Ethics* is called clinical pragmatism, and has its philosophical roots in the pragmatic philosophy of John Dewey and William James. The instructor supplements the clinical pragmatism framework with the work of another pragmatist, Henry David Aiken, who argues for four distinct levels of moral discourse that integrate sophisticated use of moral reasoning and human feeling.[5]

The instructor believes the clinical pragmatism framework is optimal for education of health professionals, as the framework utilises a very familiar method for organising clinical thinking – in terms of (moral) assessment, (moral) diagnosis, consideration of (moral) options, and evaluation. Decision makers are required to assess a variety of ethically relevant contextual factors and, using a method akin to differential diagnosis, make initial hypotheses of the ethical issues present and how to resolve them.

Course description

The instructor is not a licensed nurse or other health professional. He does have extensive formal clinical experience (doctoral-level practicum for one full semester at a large academic medical center and fellowship training for one full year at another large academic medical center). Given these facts, it was important to supplement the course with several clinical nursing inputs. Thus far, the course has utilised four distinct types of clinical nursing inputs:

A permanent and tenure-track member of the standing faculty and nurse ethicist provides oversight, evaluation and mentorship to the course director on the development and evolution of the course. Both meet frequently to discuss the course, its evolution and address any issues.

A teaching assistant (usually a doctoral student with an undergraduate or advanced practice nursing background) is paired with the course director to provide in-class clinical information, as needed, and mentors mock ethics consultants outside of class in a group discussion format to provide clinical information for the live role-play simulations. The course is a requirement for all undergraduate nursing students.

A 'real' nurse provides a guest lecture at the end of the semester to answer questions about ethical and professionalism issues encountered in practice.

On occasion, visiting scholars observe and/or participate in the course to adapt ethics teaching and learning techniques to other settings.

Course evolution

The course evolved into its current form through several steps. The first is based on the course director's clinical experience in ethics consultation methodology, including training by doing numerous ethics consultations with experienced ethics consultants at a major academic medical center as part of his fellowship experience, followed by dissertation work on ethics consultation methodologies, including mediation.[6] The course director also had the opportunity to be a group facilitator for a required ethics course for second-year medical students in 1998. It was at this point in time that the course director was introduced to the textbook, *Introduction to Clinical Ethics*. The course director, using these teaching and ethics consultation training experiences, created several cases to be portrayed live during class. The format was first introduced to undergraduate liberal arts students taking a philosophy course in biomedical ethics in the spring of 1999. The course was also developed for the University of Pennsylvania School of Nursing in the autumn of 2005 and the cases and techniques remain largely the same to this date.

Current course structure

The first part of the course is intended to provide nursing students with the preparation necessary to successfully conduct a series of live role-play simulations on the ethical issues listed in Table One and the specific cases in Table Two. This first part of the course has lectures and discussions focused on: 1) ethical theories;[7] 2) the context of the health care environment; 3) the use of the clinical pragmatism framework;[8] and 4) how to integrate reason, theory, emotion, affect, and interpersonal dynamics in ethical decision making; there is also a review of videos[9] or live role-play of a 'mock' or practice ethics consultation,[10] followed by discussion of key points regarding the process and substance of ethics consultations. In addition, to prepare for evaluating the simulations, a class session is devoted to how to give and receive feedback.

Class is usually three hours long and is conducted once per week; this allows time for a quiz at the beginning of class, followed by an evaluation of the previous week's case, which usually leaves approximately two hours for the live role-play of simulated ethics consultation cases.

Why ethics consultations

Ethics educators reading this paper may wonder why much of the course focuses on ethics consultations, especially since it is well known that development of consultation competencies requires advanced training in a variety of process and interpersonal skills, as well as skills in ethical discernment, judgment and critical thinking.[11] There are

several reasons for this focus. First, John Fletcher, et al. indicate that health professionals will become the main human resources for ethics consultation and bedside ethical decision making so it makes sense to simulate ethics consultations in order to acclimatise students to their function. Moreover, simulation of ethics consultations may spark interest in student nurses to serve on ethics committees and consultation teams when they begin clinical practice. Second, simulation of ethics consultations provides a built-in structure to showcase and safeguard the critical thinking skills necessary for ethical decision making. Third, simulation of ethics consultations demonstrates why and how clinical ethics decision making should not be divorced from, but rather integrated into, clinical decision making. Such modeling allows students to learn how to anticipate potential ethical issues and develop the skills to be pro-active in addressing them. Fourth, presentation of cases seems to be the norm in the education of health professionals. Fifth, the interactive element in presenting such ethics consultation cases live, in front of one's peers, makes the learning process more enjoyable and less tedious than pure lecturing and other one-way forms of knowledge delivery. Sixth, simulation allows nursing students (who are for the most part in their second, pre-clinical year) the opportunity to understand how complex the clinical environment can be and prepares them for working in concert with other health professionals to resolve complicated issues.

Teaching philosophy and learning styles

The specific course requirements are a deliberate attempt to target four different learning styles: kinaesthetic, reading/writing, aural, and visual.[1,2] Some exercises capture one learning style while others may capture more than one. Visual learners prefer and retain information best when it is presented in the form of charts, graphs, process flow diagrams, and other visual aids. Aural learners prefer to hear information, such as lectures, podcasts and speaking with others. It should come as no surprise that many in academia prefer the written word (whether in a book, on a projected screen or another medium). Kinaesthetic learners prefer to rely on experience, examples, simulation and other forms of practical engagement.

The course uses brief, five-question quizzes, given at the beginning of class, to test comprehension and ensure adequate out-of-class preparation of the assigned reading material. A recent evolution of the course features a replacement option for the quizzes: students may prepare their own outlines of the reading material in lieu of quizzes, or complete and hand in the information on 'redacted' PowerPoint slides posted onto the course's online learning management system. This learning activity focuses on reading/writing.

The live role-play simulations of ethics consultations target the kinaesthetic and aural learning styles as much as a classroom environment can. Skills such as thinking on one's feet, argumentation, and mediation of communication are targeted. There is much out-of-

class preparation that students and faculty engage in to make these simulations a success. First, actors are provided their 'motivations' two weeks before the simulation and are asked to write out how they will be playing their character in light of the provided motivations and the case. The course director meets with the actors so that the simulation will proceed smoothly, without continuity flaws, by ensuring that the actors all have the same basic demographic and clinical information to the fullest extent possible, without disclosing individual actor motivations. Some actors also conduct research on their roles, especially if they are asked to play the part of a clinician who must have certain clinical information about the patient. The teaching assistant meets with students who will be playing the ethics consultants to ensure they have the clinical nursing information necessary for the case and to assist the consultants in preparing their strategy for the consultation.

During the role-play simulations, students in the audience are observing the process and substance of the evolving ethics consultation. Several select students are provided with a detailed evaluation sheet that matches the clinical pragmatism framework utilised to structure the consultation. These evaluators complete their sheets and provide verbal feedback to the consultants and actors immediately following the consultation (or if time runs short, during the next class period). A recent evolution of the evaluator role involves the evaluators typing up their comments and sending them to the teaching assistant, who prepares aggregate and anonymous comments for the actors and consultants to gauge their performance from their peers. As mentioned above, the course director provides a lecture and coaching session on how to give and receive feedback before the simulations are scheduled. The evaluators, actors, and consultants in particular, and the rest of the audience in general, use all of the learning styles in these simulations.

The week following the simulation, the course director provides a structured assessment and evaluation of the simulation and provides the bioethical substance behind the options generated and decisions reached during the simulation. This activity reinforces the proper use of the clinical pragmatism framework as well as the substantive knowledge that the students will need when they take the final exam and encounter similar issues in their own clinical practice years later. This activity also utilises all four learning styles. In the future, the course director hopes to include ethics debriefings with graduates of the course in their later clinical years to provide additional reinforcement of the core bioethical concepts in the course.

The comprehensive final exam, given at the end of the semester, focuses on uptake of key bioethical knowledge and critical thinking skills. One-third of the exam involves very short answers (usually one to two sentences) and students have the choice of about fifteen questions and must complete ten. The other two-thirds are short essays and again, students have a choice of ten and must complete five of the essays. This activity targets the reading/writing learning style.

In general, the class is highly interactive, even during the lectures that form the introduction to the course material and provide structure, substance and process for the simulations. Class discussions target all four learning styles as well because the course director makes a concerted effort to use additional, real-life examples during lectures and discussions.

Evaluation

In addition to the evaluation of the simulations mentioned above, there are four other forms of evaluation in the course. The students are asked to evaluate the course at the end of the semester, using both closed-ended and open-ended questions. The course director leaves the room and the teaching assistant collects all evaluations and hand delivers them to the administration. To preserve the confidentiality and candour of responses, only after grades are recorded does the course director have access to the evaluations.

If visiting scholars are present during the course, a separate evaluation, prepared by the visiting scholar and approved by the course director, may also be completed by students. The visiting scholars are usually interested in the educational content and achievement of objectives for the purposes of replicating or using the teaching methods in other settings.

The course director also solicits informal feedback from the teaching assistant about their teaching performance, problems encountered in the meetings outside of class with the mock ethics consultants, and other feedback. The feedback has been uniformly positive and the professional development of the teaching assistants has been enhanced as a result of their unique participation in the course. Unsolicited, informal feedback from fellow nursing faculty has also been uniformly positive.

Future directions

While the course has undergone some 'tweaking' over its ten-year evolution, the course director has a variety of ideas for future directions that could further improve undergraduate nursing ethics education. While the actors in the mock ethics consultations report in their reflection papers that it is useful to be put in the shoes of patients, families and clinicians, the course director believes that the use of standardised patients (SPs) – professional actors who know how to play the part of patients and are utilised in a variety of health education settings – might result in better educational outcomes, as students can concentrate on using the clinical pragmatism framework as ethics consultants. This is especially the case if the course enrolment remains at approximately sixty students per semester. This number of students in one section of the course means that currently some students will not get to play the role of ethics consultants.

An idea for future courses to increase the level of feedback on interpersonal and process issues is to videotape the sessions and allow

consultants and actors to visually assess sessions and match feedback from evaluators with clips from the simulation. Moreover, it is now possible to podcast the lecture material, in conjunction with PowerPoint slides, for student use (either on their computers or on a variety of personal media players) and therefore maximise class time for the simulations. This innovation represents yet another future direction for the course.

The University of Pennsylvania School of Nursing will be purchasing educational technology that will allow instant polling of students using wireless handsets tied to specific cues during lectures using PowerPoint. The course director has established a start-up educational consulting company (www.e-four.org) to make use of several of these ideas for future innovations in the course. It would be possible to combine several of the ideas for the future expressed above (videotaping and the use of SPs) to stage several scenes and edit them into PowerPoint and use the polling technology so that students can, as a group, make certain choices at specific decision points to chart the course of the consultation. Knowledge to help the students make the proper choices can be presented before or immediately after such choices have been made, thus efficiently combining the didactic part of the simulations with the experiential component.

One idea for testing this new format would be to evaluate its effectiveness for the nursing (and other health professional) bioethics learning environments using a variety of techniques. The easiest is to compare student evaluations from courses utilising this new format to those done previously using the more traditional, live role-play simulations. An ideal test would be a randomised, controlled trial of the formats. Students, who are required to take the course, would be randomly selected to participate in one of two sections of the course: the traditional, live role-play simulation format; and the pre-recorded, standardised patient simulation, informed choice format using the polling technology for navigating one's way through each simulated case.[13]

Commentary

It would be interesting to replicate the course (or at least the interactive, experiential simulations) in other settings. In this spirit, Appendix One has the Spring 2008 Syllabus, and others engaged in ethics teaching, who wish to develop similar courses are encouraged to liberally use the syllabus materials with appropriate citation and acknowledgement. Use of the e-four.org educational format is copyrighted and may be pending patent, so its use is governed by intellectual property laws. Persons interested in receiving more detailed information about this educational format should contact the author directly.

While Lachman, Grace and Gaylord believe that ethics teaching in nursing should not be 'outsourced' to other departments or schools at the university (such as philosophy departments or ethics centers), it would be interesting if a course of the type described in this paper

could have future nurses and future physicians in the same class. Since these two groups will need to collaborate in a variety of ways in their professional careers, modeling such collaboration during simulated ethics cases may help to establish the sort of professional relationship that is necessary for these two separately educated groups to work together.

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Table One: issues covered in undergraduate ethics for nurses course

1. Privacy and confidentiality
2. Communication, truth telling and disclosure
3. Determining patients' capacity
4. Informed consent
5. Treatment refusals by capacitated patients
6. Death and dying
7. Forgoing life-sustaining treatments in patients lacking capacity
8. Paediatrics
9. Reproductive issues

Table Two: cases used

Notes: The cases correspond to the ethical issues in Table One, such that Case One is about Privacy and Confidentiality, etc. In all of the cases, the names and features used have been changed to protect patient confidentiality, as some of the cases are based on features from real-life ethics consultations.

Case One: privacy and confidentiality

'Love letter to an ethics committee'

As the ethics committee for one of the State's flagship medical centers, you receive a strange letter from Danielle Richardson, RN, MSN, MPH, a public health nurse in the Gotham County Health Department. Her letter explains that James Nottingham, a mildly retarded thirty-four year-old man who lives in a rural group home, has been recklessly infecting women in Gotham County with HIV. James was tested for HIV one year ago, after an anonymous tip to Nurse Richardson from a concerned citizen. He was infected many years ago through a blood transfusion when he was involved in a car accident. He has been living in the group home for four years. Nurse Richardson wants to warn all the women, and their guardians, in James' group home about James' HIV status as well as contact all known past sexual partners to suggest they seek HIV testing. If this does not stem James' promiscuous rampage, Nurse Richardson states in her letter that she will be forced to seek institutionalisation and/or jail for James. She is asking the assistance of the ethics committee to determine whether the course of action she outlines is ethically and legally feasible.

The ethics committee, instead of writing a letter in response, has decided to facilitate a meeting between Nurse Richardson, James Nottingham's legal guardian and father, William Nottingham, and James' social worker, Jessica Duvane. Mrs Angela Reardon, the mother of Nellie Reardon, one of James' past girlfriends from his group home, has called the ethics committee several times and vehemently

demanded to attend the meeting. The ethics committee has selected several of its members to facilitate this meeting.

Case Two: communication, truth telling and disclosure

'The matching game'

As chair of the ethics committee, one of the transplant clinical nurse specialists (CNS) calls you with a problem. He has been caring for a six-year-old little girl with kidney failure. The girl is receiving three dialysis treatments every week to clean her blood. The girl's type-matching tests revealed that she would be a difficult match. Last week, her situation became somewhat more dire, prompting the surgical team to request that the girl's family members be type-matched so that one of them might donate one of their kidneys. The girl's two brothers were too young to serve as donors, and her mother did not match. The girl's father, however, did match. In fact, tests revealed that the father had anatomically favourable circulation for transplantation.

The transplant CNS met with the father alone after the test and gave him the results. The CNS told the father that his daughter's prognosis after the surgery is uncertain, given her extensive kidney disease. After some thought, the girl's father said that he did not want to donate a kidney to his daughter. He admitted that he did not have the courage and that, particularly in view of the uncertain prognosis, he would rather not donate. The father asked the CNS to tell everyone else in the family that he was not a match for his daughter. He was afraid that if they know the truth, they would accuse him of allowing his daughter to die. He felt that this would 'wreck the family'. The CNS is asking you for guidance in this matter. You decide to convene an ethics committee meeting to discuss the options in the case.

Participants: ethics committee members; Robert Sharmer, BSN, MSW, Transplant Clinical Nurse Specialist; Earl Robinson, the little girl's father; Mary Robinson, the little girl's mother.

(Note: One of the 'secret motivations' in this case is that the father has contracted a sexually transmitted disease due to unprotected sex outside of his marriage and wishes the nurse to lie both to protect his marriage and his daughter from contracting the disease should he donate.)

Case Three: determining patients' capacity

'Screw superman!'

It's 4 am when your pager beeps loudly and interrupts your slumber. You reach for the phone and return the page. It's one of the psychiatry night nurses Delia Rosen, RN. She explains that she was asked to evaluate a patient who had recently been transferred to the rehabilitation unit. The patient, a Mr Harrington, was involved in car crash a few weeks ago. He wasn't wearing his seatbelt and he was catapulted out of the car, landing thirty feet away on his head and back. Tests revealed a severed spinal cord injury near the base of the neck, resulting in permanent quadriplegia. Mr Harrington is fully aware

of the seriousness of his injuries and realises that he will most probably never regain physical sensation or function below his neck. While in the intensive care unit, Mr Harrington was in a minimally conscious state (not quite a coma). He was transferred to the rehab unit after regaining consciousness.

Delia explains that her team was consulted last week to evaluate Mr Harrington for depression. They found him to have a flat affect at times, and talking to him only angers him. One time the psychiatrists mentioned how Christopher Reeve had survived and even flourished after his injury. 'Screw Superman', was all Mr Harrington had said. The psychiatric team decided to prescribe him an anti-depressant. After making several requests to have his feeding tube withdrawn, the psychiatrists increased the dosage of Mr Harrington's antidepressant to its maximum level and added an antipsychotic agent. 'I know it's 4 am, but doesn't a patient have a right to refuse life-saving medical treatment?' Delia asks you. You suggest that perhaps this case would be best handled in the morning, when all of the people involved can meet and discuss the issue.

Case Four: informed consent

'Doctors give orders and nurses follow them'

You receive a phone call from the head nurse at the community hospital across the street from the medical centre. She tells you that she and her nurses have just met and decided that they will not sedate a patient, Seamus Sullivan, who is refusing surgery. The nurse, Barbara Mendel, RN, describes the case. Mr Sullivan was transported against his will by the sheriff of a rural county to the medical centre for surgery. He has a very large and very messy mass on the side of his head. The Ear, Nose, and Throat (ENT) surgeons evaluated Mr Sullivan and determined that they could remove the growth. They scheduled the surgery, but when transport came to bring Mr Sullivan over to Medical Center for surgery, he refused to get on the stretcher. The nurses decided not to force him to go. When ENT heard what happened, Dr Morrison, the resident in charge of Mr Sullivan's care, came over and was very angry. He yelled at one of the nurses that he would order sedation for the patient if he refused again. The nurses called a staff meeting to talk about the issue. They all agreed that they could not in good conscience sedate a patient just so he could be taken to surgery against his wishes. The surgery is in his best interests and Mr Sullivan seems 'slow', but the nurses have a moral problem with the course of action the doctors are proposing. You agree to talk to the surgeons and investigate the case.

Case Five: treatment refusals by capacitated patients

'Jamar Jackson'

Jamar, a fifteen year old black boy, was involved in an accident when an eighteen-wheeler sideswiped his bicycle on Roosevelt Boulevard. Jamar has a serious closed head wound. The swelling

inside his skull is killing his brain. He has a tremendous wound on his back. His back is a huge flap of skin and tissue that reveals ribs. He is receiving powerful antibiotics to stave off infection and extensive wound care – scrubbing and cleansing the wound to keep it clean. Neurology has evaluated Jamar and determined that he probably will never regain consciousness and his scans reveal diffuse and permanent brain damage. The surgeons have met and determined that, based on Jamar's grim prognosis, surgery to close his wound is not indicated. They want to stop the antibiotics as well. Jamar will surely die. The surgeons, knowing the general distrust some black families feel towards the medical system, feel that Jamar's family might perceive their wish to withdraw and withhold treatment as an instance of discrimination. They have asked for the involvement of the ethics consultants to facilitate the meeting where they will disclose Jamar's condition and inform his family of their desire to withdraw and withhold treatment. The family knows Jamar is in a serious condition, but not that the surgeons are refusing to operate on his back and want to withdraw the antibiotics. (Note to ethics committee members: this must be a group meeting at some point, although you may choose to meet with the doctors first just to make sure you have all the facts and to prepare the doctors for what you will do. Your job is to help the family understand the doctors' wishes and help to generate options that will satisfy the interests of all parties.)

Parts: Ester Jackson, Jamar's mother; Dr Richard Gunderson, chief of paediatric surgery; Delmar Morris, Jamar's cousin; ethics consultants.

Case Six: death and dying

'I won't kill him!'

Herbert Solomon was diagnosed with end-stage colon cancer ten months ago. A veteran of Vietnam, Herb sought surgery and chemotherapy treatment at the Veteran's Hospital. The surgery successfully removed the primary tumour in the colon, but the surgeons discovered advanced metastases to the liver. Herb has been taking increasing amounts of oral morphine for pain control – in a sense self-medicating, since the VA pharmacy dispensed the morphine elixir in a 250 cc container. Despite his morphine intake, Herb is still not fully relieved of his pain. Two days ago, Herb found that he could not keep food down and started vomiting dark red blood, an indication that his entire digestive system has shut down. Herb was admitted to the VA hospital, a tube inserted into his stomach to suction off his undigested stomach contents and blood. Herb lost consciousness yesterday, but he is often agitated. The physicians explained to the family that his agitation is probably due to toxins building up in his brain from hepatic encephalopathy, the inability of the liver to convert toxins and excrete them. The son, a college educated biology major who has studied medical ethics, asked the bedside nurse if she is providing adequate doses of morphine to control his pain. The nurse emphatically tells the son that she will not give more morphine for fear

of hastening his death by respiratory depression. The son, angry and frustrated with the nurse, decides to contact the ethics committee.

Parts: Diego Rivera, the patient's son; Felicia Cohen, oncology nurse; Dr Wahid Hassan, oncology attending physician; ethics consultants.

Case Seven: forgoing life-sustaining treatments in patients lacking capacity

'Proxy paradox'

Janet Busch, a fifty-year-old female motor vehicle crash victim, arrives in the emergency room (ER). The car veered off a small suburban road, went down an embankment, and rolled over, pinning her. On the scene, she arrested briefly and had to be intubated and resuscitated. She arrived in the ER unconscious. She had no visible injuries other than a minor scalp laceration. By examining the CT scan of her head, the trauma team discovered she had a serious closed head wound. The CT reveals no other internal injuries other than 'shock bowel', profuse swelling of the bowels consistent with an unrestrained motor vehicle crash victim being thrashed around. After blood is drawn for tests, she is transferred to the neurological intensive care unit. A resident on the trauma team summarises her poor prognosis as 'a good organ donor' during rounds later that day.

Larry Busch, Janet's forty-seven-year-old husband, and driver of the car, is brought into the ER a few minutes later, alert but obviously scared. After a full trauma team work-up, a CT scan finds a minor concussion, no broken bones, and no other internal injuries. After blood is drawn for tests, the patient is transferred to the general neurology floor.

Janet began to seize after transfer to the neurological intensive care unit. Her pulse was fast and irregular and her blood pressure was rising – clinical signs of significant brain swelling and possible unsurvivable brain injury from lack of oxygen. One hour later, the blood tests had come back from the lab. Test results reveal that the wife had a blood alcohol level of 0.235 and the husband 0.199 (Pennsylvania's legal limit is 0.08).

After several days in the neurological unit without any clinical changes, for better or worse, the neurosurgeons decide to perform another CT scan of Janet's head, and the results were even worse than the previous scan. The neurosurgeons conclude that she has a nonsurvivable head injury and will probably die if removed from ventilator support. In addition, Janet's 'shock bowel' has progressed to full necrotic bowel, due to the lack of oxygen to her vital organs when she arrested on the crash scene. She will die in several weeks from multi-organ system failure unless dialysis is performed on her blood, antibiotics given to prevent infection, and complete IV nutrition provided. Janet's daughter, Joan, had been the proxy decision maker while Larry was incapacitated by his own minor head injury. Now that Larry has recovered somewhat, he is legally entitled to make treatment decisions for his wife. The neurosurgeons meet at Larry's bedside, with

Joan present, to inform Larry of his wife's grave condition. With tears in his eyes, Larry vehemently refuses to discontinue Janet's life-sustaining treatments. The neurosurgeons, concerned about the futility of continuing to provide life-sustaining treatments for Janet, decide to involve a group of ethics consultants to mediate the case.

Players: ethics consultants; Dr Malik Jones, neurosurgeon; Joan Busch, Janet's daughter; Larry Busch.

Case Eight: paediatrics

'Got milk'

Virginia Patterson is a twenty-eight-year-old new mother with an extensive psychiatric history. She is bipolar (manic-depressive) and is currently taking a drug called zolpidem used to de-escalate extreme manic ('I'm superwoman; I can do anything!') or depressive episodes. She is breastfeeding and wants to continue to do so because she feels that it promotes bonding and is healthier for her baby. The neonatologist, Dr Hernandez, presented the benefits and burdens of breastfeeding to her before discharge: breastfeeding is best for the baby because the baby receives love, attention and the mother's antibodies; it is good for the mother because it encourages bonding; and research shows that breastfeeding is the first step to encourage other positive child rearing duties. However, the zolpidem that Virginia takes represents an unknown risk to the child (and Virginia says she is allergic to lithium). The drug is present in the breast milk and can act as a powerful sedative on the child. Cases of respiratory depression in newborns have been reported in the literature from mothers who take the drug and breastfeed.

Kathleen Henderson, RN is a home health nurse charged with providing newborn weight checks for Virginia's baby. During one visit, she notices that Virginia has not refilled her bottle of zolpidem from two weeks ago. She might have discontinued the zolpidem in order to safely breastfeed. However, without zolpidem, she might represent a danger to her child during one of her manic or depressive mood swings. Kathleen has a legal obligation to report this fact to Child Protective Services. She phones Virginia's psychiatrist, Dr Martin, to discuss the issue. Kathleen phrases her dilemma with several questions: 'who is my patient?'; 'can we force her to take her drugs so she will be a good mother even though that represents a potential harm to her baby if she continues to breastfeed?'; and 'can we force her not to breastfeed?' The question of reporting is moot, Kathleen says, but the psychiatrist urges her to wait until all parties can meet to discuss the issue. Afraid for her license should she not report and concerned about the numerous ethical issues, Kathleen tells the psychiatrist that she wants her ethics committee involved in facilitating such a meeting.

Parts: Virginia Patterson, the twenty-eight-year-old mother; Patricia Delgado, Virginia's case manager from the Mental Health Department; Simon Loeb, Virginia's case worker from Child Protective Services; Dr Juan Hernandez, Virginia's neonatologist (the newborn

baby doctor); Dr Josephine Martin, Virginia's psychiatrist; Kathleen Henderson, the paediatric home health nurse; ethics consultants.

Case Nine: reproductive issues

'Womb for rent'

Jeff and Sabrina Tyler had been trying to conceive a child for a year, when they decided to see a fertility specialist. As it turned out, they learned that Sabrina had a condition that had rendered her unable to conceive and bear a child. Both of them had healthy gametes. The couple, with the assistance of their fertility doctor, Mabel Rogers, investigated all of the various options – adoption, in vitro fertilisation (IVF) of a surrogate mother using gametes from Jeff and Sabrina, and other forms of fertility assistance. Jeff and Sabrina decided that they would prefer to have a child that is the biological product of both of them. That was the goal they had tried to achieve in conceiving naturally, and using in vitro fertilization of a surrogate mother from their gametes would provide them with the result they wanted.

Jeff and Sabrina spent six months researching the various organisations and agencies that matched couples with surrogate mothers. After many interviews, they settled on Rebecca Stevens, a young, healthy woman. Jeff and Sabrina were successful accountants and what sold them on Rebecca Stevens was her goal to go to college and study finance in the hopes of becoming a Certified Public Accountant. As part of the legal contract, Jeff and Sabrina agreed to pay for Rebecca's living expenses in an apartment near their house.

The fertility doctor described the process for Jeff, Sabrina, and Rebecca to ensure that everyone understood the risks and what would transpire. It was usually necessary to create several embryos from Jeff and Sabrina's gametes, analyse them, and implant several embryos in the hopes that at least one would implant in Rebecca's uterus. In addition, Dr Rogers freezes ten additional embryos in case they need to try IVF again. It may be necessary to selectively reduce embryos if too many implanted, as that might endanger Rebecca, Dr Rogers explained. Everyone was comfortable with that process.

As it turned out, only one of the four embryos injected into Rebecca's uterus implanted successfully. Everyone seemed as pleased as could be. However, at her twenty-four-week obstetrician visit, at which Dr Rogers conducted an ultrasound to check on the progress of the fetus, she discovered that the fetus had a developmental anomaly and would be born with a devastating heart defect called hypoplastic left heart syndrome. Dr Rogers refers the couple to a paediatric cardiac surgeon, who explains the risks and benefits of trying to correct this condition after the baby is born. Rather than go through the series of operations necessary to treat their future child, using a cost-benefit analysis, Jeff and Sabrina determine that it would be better for them if Rebecca terminated this particular pregnancy and they tried again with the other embryos that Dr Rogers had frozen for just such an occasion.

Jeff and Sabrina asked Rebecca to come over to their house for dinner and they discussed the situation. Rebecca's jaw dropped when she learned what Jeff and Sabrina wanted her to do. While she understood that it might be necessary to selectively reduce implanted embryos, she had never agreed to terminate the pregnancy unless there was a severe defect that was incompatible with life. She explained to Jeff and Sabrina that the operations to correct the heart defect could save their baby and she was opposed to terminating the pregnancy on those grounds.

Upon hearing what happened, and hoping to prevent positions from becoming entrenched, Dr Rogers called Jeff, Sabrina, and Rebecca to ask if they might seek the counsel of the hospital's ethics committee. Wishing to avoid the costliness of involving lawyers at this stage, they consented to appear before the ethics committee to learn what options might be explored in their case.

Parts: Jeff Tyler; Sabrina Tyler; Rebecca Stevens; Dr Rogers; ethics consultants.

ENDNOTES

1 Lachman VD, Grace PJ and Gaylord N, 'Bioethics education: an inadequate foundation for ethical nursing practice?', American Society for Bioethics and Humanities Annual Meeting, Denver, Colorado, October 26, 2006.

2 While the instructor borrows simulation techniques from mediation training, it should be noted that simulation is a well-documented and tried-and-true method for ethically teaching clinical skills to health professionals. See, Ziv A, Wolpe PR, Small SD and Glick S, 'Simulation-based medical education: an ethical imperative', *Academic Medicine*, vol. 78, 2003, pp. 783–788.

3 Fletcher JC, Lombardo PA, Marshall MF and Miller FG, *Introduction to Clinical Ethics*, 2nd edition, Frederick, MD: University Publishing Group, 1997; Fletcher JC, Spencer EM and Lombardo PA, *Fletcher's Introduction to Clinical Ethics*, 3rd edition, Frederick, MD: University Publishing Group, 2005.

4 Schroeter K, Derse A, Junkerman C and Schiedermayer D, *Practical Ethics for Nurses and Nursing Students: a short reference manual*, Frederick, MD: University Publishing Group, 2002.

5 Aiken HD, *Reason and Conduct: new bearings in moral philosophy*, New York: Alfred A.Knopf, 1962; Perlman DJ, 'Putting the "ethics" back into research ethics: a process for ethical reflection for human research protection', *Journal of Research Administration*, vol. 36, no. 1, 2006, pp. 13–23.

6 Perlman DJ, *Transformative Ethics Consultation: a supplement for ethics facilitation for emotionally charged conflicts*, PhD Dissertation, University of Tennessee, Knoxville, 2000; Perlman DJ, 'Mediation and ethics consultation: towards a new understanding of impartiality', American Bar Association James Boskey Memorial Essay Contest, 2001, available at http://www.abanet.org/dispute/perlman2001.pdf and http://www.mediate.com/articles/perlman.cfm [accessed March 3, 2008].

7 Solomon WD, 'Normative ethical theories', in Reich WT (ed.), *Encyclopedia of Bioethics*, vol. 2, New York: Simon and Schuster MacMillan, 1995, pp. 736–748.

8 Fletcher, Spencer and Lombardo, *Fletcher's Introduction to Clinical Ethics*, Appendix 2, pp. 339–347.

9 Loyola University maintains several Apple QuickTime videos of mock ethics consultations available at: http://bioethics.lumc.edu/online_masters/ECE_skill.html

10 Fletcher, Spencer and Lombardo, *Fletcher's Introduction to Clinical Ethics*, Appendix 3, Case 1, pp. 349–352.

11 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Health Care Ethics Consultation*, Washington, DC: ASBH, 1998.

12 Fleming ND and Mills C, 'Not another inventory, rather a catalyst for reflection', *To Improve the Academy*, vol. 11, 1992, pp. 137–155.

13 Of course, there are a variety of ethical and regulatory issues to be considered in the latter type of test, but these are beyond the scope of the present paper. See, Lipman AJ, Sade RM, Glotzbach AL, Lancaster CJ and Marshall MF, 'The incremental value of internet-based instruction: a prospective randomized study', *Academy of Medicine*, vol. 76, no. 10, 2001, pp. 72–76, available at http://www.musc.edu/humanvalues/manuscripts/Incremental%20value%20of%20internet-based%20instruction.pdf [accessed February 19, 2008].

Appendix One

Spring 2008 Syllabus (Note: certain private information has been redacted.)

NURS 330, Section 001, Spring 2008, Healthcare Ethics

Meeting Times: 5.00–7.50 pm, Mondays
Meeting Place: Claire M Fagin Hall (formerly the Nursing Education Building) Room 110
Instructor: David Perlman, PhD, Senior Lecturer, Penn SON and Associate, Penn Centre for Bioethics (bio available here)
Email: perlmand@nursing.upen.edu
Office and Office Hours: By appointment
Department Mailbox: Claire M Fagin Hall, Campus Code 6096
TA Office and Office Hours: By Appointment

Course Texts:

1. Fletcher JC, Spencer, EM and Lombardo PA (eds), *Fletcher's Introduction to Clinical Ethics*, 3rd edition, Frederick, MD: University Publishing Group, 2005, ISBN: 1-55572-027-7 (**Required Text** – Note: the 2nd edition will not correlate to the syllabus, readings, or quizzes).
2. Articles on Blackboard (https://courseweb.library.upenn.edu)
3. Schroeter K, Derse A, Junkerman C and Schiedermayer D, *Practical Ethics for Nurses and Nursing Students: A Short Reference Manual*, Frederick, MD: University Publishing Group, 2002, ISBN: 1-55572-066-8 (**Optional Text**).

Introduction and course objectives

This is a survey course in biomedical ethics, with a focus on ethical issues in the practice and delivery of professional nursing care. There are two objectives for this course. The first is to instill a basic understanding of what biomedical ethics is. We will accomplish this by briefly studying some classical approaches to ethical theories, followed by more detailed exploration of how ethical issues arise in health care. The second objective is to improve your critical thinking and communication skills in relation to potential ethical issues you will encounter. To accomplish this you will write essays for examinations, participate in highly interactive mock ethics consultations, and collaborate on group presentations.

Quizzes or outlines (150 points, 15% of total grade)

Quizzes to test your understanding of the reading material will be given for the first five minutes of each class session (except the first,

third, and last). There will be **no make-up** quizzes (regardless of whether the absence is excused or not), so make sure you get to class on time. As an alternative to quizzes, students may prepare an outline of the reading material either by creating their own outlines or completing the redacted slides posted on Blackboard for each reading. Finally, students unhappy with particular quiz grades can replace a quiz grade by submitting an outline within **one week** of the quiz.

Final exam (300 points, 30% of total grade)

The final exam for this course will be comprehensive and divided into two parts: (1) A very short answer section (worth 1/3 of the total grade) and (2) a short essay section (worth 2/3 of the total grade). A study guide is available on Blackboard to help students prepare for the exam, including sample questions.

Class participation (150 points, 15% of total grade)

This class requires active and frequent participation. Consistent attendance, participation in discussions, asking questions during lectures, talking to the instructor and teaching assistant during office hours or via email, and, of course, discussing the mock ethics consultations are all forms of class participation. This grade is determined subjectively, depending on your attitude towards the material, your fellow students, and the instructor and teaching assistant.

One third of your participation grade will be based on the frequency, quality, and relevance of comments made during class. Two thirds of your participation grade will be based on your class attendance, preparation of the reading material, and serving as a mock ethics consultation evaluator.

Mock ethics consultation presentations (400 points, 40% of total grade)

Let's face it. Sitting in class for 3 hours every week listening to some instructor drone on and on about ethics is not your idea of a good time. Thus, I have tried to structure the class to optimize learning, but also to be fun, interactive, and as realistic as a classroom setting will allow. The success of each class will depend on the amount of effort and enthusiasm you put into it. Early in the semester, a sign-up sheet will be circulated. You will sign up two times:

To play an ethics committee member or to play an 'actor' (ie, patient, family member, or clinician)

To serve as an evaluator of the ethics committee

Your mock ethics consultation grade will be worth 40% of your total grade for the class or 400 points. Portraying an ethics committee member or an actor will be worth 400 points You will have the opportunity to select the date on which you will participate in the mock ethics consultations, so if you have a particular clinical interest or specialty, you may wish to correlate the dates and topics listed in this

syllabus and sign up for that date. Or, if you have other exams or commitments, you may wish to avoid certain dates. **Please bring your up-to-date calendars to class, because switching will not be possible in a class of this size.**

Details on being an ethics committee member

As an ethics committee member, you and a number of other students will help the actors reach a resolution to their case. You will use the clinical pragmatism framework, your knowledge of the chapter of the text for which you are scheduled, and your interpersonal skills to help the family members and clinicians who are either in conflict or uncertain about what ethical options exist to reach a resolution.

Thus, it will be necessary for the ethics committee members to meet outside of class to build a strategy and research the problem and medical condition(s) at the crux of the consultation. The only information you will have regarding the case are the participants' names and a brief summary of the case as it would appear on a consultation request in the patient's chart. To provide time for the ethics committee members to meet outside of class, you will receive your case materials two class sessions before your mock consultation is scheduled. To assist in preparing the clinical information for each case, the Teaching Assistant will meet with the committee members before the consultation.

Your grade as an ethics consultant will depend on your level of preparation, participation, and use of the clinical pragmatism framework and other materials in the textbook. Because of the amount of out-of-class preparation required to successfully be an ethics committee member, your grade will start at a B- and will be adjusted up or down depending on how successful you are as a member of the committee.

Details on being an actor

As an 'actor', you might play one of a number of roles – a bereaved mother, a physician, a nurse, a social worker, a son who must make a hard choice for his dying father. To make such enactments realistic, you will be given guidelines on how to 'play' this character – not a script, but your motivation (for good examples, see the cases in Appendix 3 of our book). In addition to this motivation, you should think about the values, beliefs, biases, and knowledge that your character would hold so that you can authentically role-play that character. **You must not discuss your role or motivation with others in the class unless directed to do so by the instructor – this must be kept secret in order for the mock consultation to succeed.** Actors in the past have found it invaluable and necessary to research their role, especially if called on to play clinicians, who must be knowledgeable about the various conditions, treatments, options, and pathophysiology in the case. To assist in preparing for the consultation and to ensure a smooth experience, the instructor will meet with all actors before the

consultation to work out certain common details and answer questions. The instructor will then communicate certain information to the committee members based on the results of the meeting with the actors. In anticipation of this meeting, all actors should, using their role motivation handed out to them, prepare a paragraph or two on how they plan to play their roles.

For the actor part grade, 75% will be based on your realistic and authentic portrayal of your character during the consultation (300 points). In addition, within two weeks of the class after which your consultation takes place, you will also submit a two-page minimum, double-spaced essay reflecting on your role in the consultation. Think of the essay as a journal entry that your character would make, reflecting on the experience of being a part of the consultation. This essay will comprise the remaining 25% (100 points) of your grade as an actor. Essays will be graded as follows: Good to excellent essays will receive a check plus (√+) and 100 points; fair to good essays will receive a check (√) and 80 points; and poor to fair essays will receive a check minus (√-) and 60 points.

Details on being an evaluator

The ability to give and receive constructive feedback is a good leadership skill for anyone to have. As an evaluator, your job is to provide feedback to the ethics committee and actors. After providing training on how to give and receive feedback during one of our class sessions and providing you with an evaluation sheet, your job is to evaluate the committee. During the consultation, pay particular attention to the substance, process, and interpersonal elements of the interaction. You will use your evaluation to jump-start group discussion of the process and options reached by the committee towards the end of class and during my presentation of the case in terms of the clinical pragmatism framework in the class immediately following the case. For the evaluation phase of the clinical pragmatism framework, you will need to work outside of class and bring in your evaluation for discussion at the beginning of the next class. Your grade for this small group work will comprise a large part of your class participation grade.

Evaluators will be asked to type up their evaluations and place their name to receive credit for evaluating. In addition, evaluators should prepare another version of their typed evaluation without their name for the instructor and/or teaching assistant to provide feedback to the ethics consultants and actors in an anonymous fashion.

Role	Points Possible out of 400	Workload
Ethics committee member	400 points	• Advance, out-of-class preparation required • Mastery of material required • No additional work after the consultation
OR	OR	
Actor	400 points (300 points, actor portrayal; 100 points, reflection essay)	• Some advance preparation • Creativity, enthusiasm, and realistic role-playing required • Essay required two weeks after case
Evaluator	0 points (grade will be built into class participation grade)	• No advance preparation • Honesty in appraising the committee's performance and asking thoughtful questions • Preparation of two typed evaluation forms

Honor statement, plagiarism, and policy on grades incomplete

Students will be held to the highest academic standards as outlined by the Code of Academic Integrity (http://www.vpul.upenn.edu/osl/acadint.html). Plagiarism is the intentional use of the words or ideas of an author as one's own without proper credit. In ethics, since ideas build on a shared intellectual history, you must acknowledge the words and ideas of others. If you use direct quotes from sources, quotation marks should be used and page numbers, titles, and authors given in a citation. If you summarize the ideas and words, the latter three elements should be cited. Plagiarism or any other form of academic dishonesty will result in a failing course or assignment grade and referral to appropriate disciplinary action. I will consider giving grades of Incomplete (I) on a case by case basis, but only in the most extraordinary circumstances and with appropriate documentation.

Grading Scale

Final grades: A+=100-97 (1000-965 points); A=96-93 (964-925 points); A-=92-90 (924-895 points); B+=89-87 (894-865 points); B=86-84 (864-835 points); B-=83-80 (834-795 points); C+=79-77 (794-765 points); C=76-74 (764-735 points); C-=73-70 (734-695 points); D=69-60 (694-595 points); and F=59 or lower (594 or fewer points).

Syllabus

Date	Topic, Assignments, and Readings
Mon Jan 28	Introduction: Overview of the Course and Sociology of the Hospital
Mon Feb 4	Quiz 1, Lecture and Discussion (Article on Blackboard)
Mon Feb 11	Skill Building in Ethics Consultation: Discussion and Evaluation of Mock Ethics Consultations (http://bioethics.lumc.edu/online_masters/ECE_skill.html) (**see below**) Appendix 2 Introduction to Clinical Ethics (ICE)
Mon Feb 18	Quiz 2, Lecture and Discussion Chapters 1, 2, and 4 ICE
Mon Feb 25	Quiz 3, Quiz 4, and Mock Ethics Consultation Case 1 Chapter 7 ICE – Privacy and Confidentiality Chapter 8 ICE – Communication, Truth-Telling, and Disclosure
Mon Mar 3	Quiz 5 and Mock Ethics Consultation Case 2 Chapter 9 ICE – Determining Patients' Capacity
Mon Mar 17	Quiz 6 and Mock Ethics Consultation Case 3 Chapter 10 ICE – Informed Consent
Mon Mar 24	Quiz 7 and Mock Ethics Consultation Case 4 Chapter 11 ICE – Treatment Refusals
Mon Mar 31	Quiz 8 and Mock Ethics Consultation Case 5 Chapter 12 ICE – Death and Dying
Mon Apr 7	Quiz 9 and Mock Ethics Consultation Case 6 Chapter 13 ICE – Forgoing Life-Sustaining Treatments
Mon Apr 14	Quiz 10 and Mock Ethics Consultation Case 7 Chapter 14 ICE – Pediatrics
Mon Apr 21	Quiz 11 and Mock Ethics Consultation Case 8 Chapter 15 ICE – Reproductive Issues
Mon Apr 28	Evaluation of Case 8 followed by guest speaker and pizza party
TBD	Final Exam

Note: This website seems to take a long time to completely load and you will need to make sure you have the following software installed in order to view the videos and slides for the third class:

Java Platform 2, version 1.50 (available as a free download at www.java.com)

Apple's QuickTime (available as a free download at www.apple.com)

Class Structure

Each class (except the first, third, and last) will usually start with a brief quiz (so be on time!).

The first couple of classes will be lecture and discussions. The classes with mock ethics consultations scheduled will proceed as follows:

Quiz and answers

Brief lecture and discussion on moral diagnosis, options, and evaluation of the previous consultation presentation

Next, live-enactment of the mock ethics consultation

For example, for the second mock ethics consultation, there will be a quiz on the chapter for that day, a lecture and discussion on the **first** mock ethics consultation, followed by the live enactment of the **second** mock ethics consultation.