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Cynda Hylton Rushton, PhD, RN
Melissa Kurtz Uveges, PhD, MA, RN
Department Editors

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Widening the Ethical Lens in Critical Care Settings

Elaine C. Meyer, PhD, RN
Franco A. Carnevale, PhD (Psych), PhD (Phil), RN
Craig Lillehei, MD
Melissa Kurtz Uveges, PhD, MA, RN

Sophia is a 5-month-old infant who was prenatally diagnosed with asphyxiating thoracic dystrophy, or Jeune syndrome, a rare autosomal recessive genetic disorder affecting bone growth. Those with Jeune syndrome have very small chests that restrict lung growth and respiratory function, "short ribs, shortened bones in the arms and legs, short stature," and polydactyly.[1] The long-term prognosis varies widely for infants diagnosed with Jeune syndrome; some survive into adolescence or adulthood, but many succumb to pulmonary insufficiency or infections during the first 2 years of life. After infancy, children with Jeune syndrome may develop renal insufficiency. Less common features include heart defects, liver disease, pancreatic cysts, and retinal dystrophy.

Sophia was born via planned caesarian delivery at 38 weeks' gestation; her mother's pregnancy had been carefully monitored. At 3 weeks of age, Sophia developed increasing difficulty with breastfeeding, experiencing cyanosis and severe respiratory distress that necessitated critical care hospitalization and intubation in the pediatric intensive care unit (PICU). Upon evaluation, Sophia was deemed to be a suitable candidate for vertical expandable prosthetic titanium ribs (VEPTR), which are inserted during a multistage surgical procedure in which metal rods are attached to the spine, ribs, or pelvis and gradually lengthened to correct deformities; in this situation, the VEPTR would expand the chest cavity to allow for lung growth and development.[2,3] VEPTR are considered an innovative surgical therapy and, although not universally accepted, evidence suggests improved survival in those who receive them.[4]

After considerable deliberation, Sophia's parents provided informed consent for the surgical intervention for the chest wall restriction that has necessitated Sophia's prolonged hospitalization. They have, however, begun to doubt the surgery, and tension is increasing between the 2 of them, and between them

Elaine C. Meyer is Faculty Associate, Center for Bioethics, and Associate Professor of Psychology, Harvard Medical School, 641 Huntington Ave, Boston, MA 02115 (elainecmeyer@gmail.com).

Franco A. Carnevale is Full Professor, Ingram School of Nursing; Associate Member, Faculty of Medicine (Pediatrics); Adjunct Professor, Counselling Psychology; and Affiliate Member, Biomedical Ethics Unit, McGill University, Montreal, Canada.

Craig Lillehei is Chair of Surgical Education, Boston Children's Hospital, Boston, Massachusetts.

Melissa Kurtz Uveges is Postdoctoral Research Fellow, Center for Bioethics, Harvard Medical School, Boston, Massachusetts.

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and staff. Sophia's father is generally supportive of the surgery, considering it a "long-term investment" in Sophia's health, but her mother is increasingly concerned that she may be suffering and that her quality of life is, and especially after the surgical procedure will be, far from what her mother had expected. Sophia's mother is preoccupied with thoughts that Sophia will require ongoing procedures and "never really be cured"; she describes feeling helpless, unable to truly comfort and care for her daughter. After inadvertently overhearing the PICU team discussing their reservations about the surgery and mentioning other patients who did not fare well with the as-yet-unproven procedure, the parents' distress has heightened, and they feel they have been misinformed and unfairly judged. They are upset about what to do and how best to help their daughter.

The couple has been married for 6 years. Sophia's mother had experienced a first-trimester miscarriage before Sophia's birth, and now they very much want to be parents. Sophia's father is an architect and her mother is a reading specialist at an independent elementary school. The family lives 80 miles from the hospital, near the mother's extended family, with whom they have a close and supportive relationship. Sophia is the first grandchild on both sides of the family.

Central Ethical Issues and Tensions

In reading Sophia's case, one is struck by the enormity of her diagnosis and the decisions that must be made on her behalf. The main ethical tension is whether the innovative surgery is in Sophia's best interests. Pediatric ethics guidelines describe the "best interest" standard as the means by which the adequacy of health care decisions that affect children should be judged.[5] Some argue that the best interest standard is also useful for identifying the limits of the authority of surrogate decision makers such as parents, but this application is more controversial.[6] The best interest standard has its origins in family law; in the health care context it provides guidance for making health care decisions by assigning weights to the interests of the patient around various health care treatment options in light of potential risks.[6] The best interest standard, rather than offering an objective measure for calculating which treatment option is most appropriate, relies on the values of the surrogates involved—specifically how surrogates weigh or translate those values when considering the potential interests of the patient in light of risks. Therefore, Sophia's best interests may be assessed differently, depending on whether her parents or health care providers are making the assessment. Typically, parents are given priority in determining their child's best interests; however, other stakeholders may question the parents' perspective if they perceive that perspective as being potentially harmful. To the extent possible, the child's perspective should be sought when formulating what constitutes their best interests, but children who are too sick or not developmentally able to voice their own perspective rely on their parents or an appropriate surrogate to make this decision.

Other ethical tensions that factor into Sophia's best interests include the level of uncertainty related to the outcome of her surgical procedure and the potential suffering resulting from the procedure. Of considerable significance in this situation are the perceptions of Sophia's experience and quality of life, the openness of family-staff communication, the extent to which parents feel well informed and supported in their decision-making, and the degree to which members of the health care team prioritize transparency and truth-telling with respect to the potential outcome of this procedure. Staff may, of course, disagree regarding the most appropriate course of treatment, especially when no clear best intervention exists and families face an innovative but unproven or unperfected treatment. Unfortunately, Sophia's parents learned the depth of the disagreement among the staff after overhearing an informal discussion around the nurses' station. Sophia's parents now sit with uncomfortable, distressing information and doubts about the transparency of communication, team cohesion, and trustworthiness of parent-staff relationships. They are having difficulty raising their concerns and knowing to whom they can turn, especially after overhearing discussions intended to be private and breaches of confidentiality in which staff named other patients. Sophia's parents feel alone and morally burdened in having to make decisions on behalf of their daughter, and their sense of being judged amplifies feelings of inadequacy, guilt, and isolation. Despite all that

has transpired, however, the family and staff still have an opportunity, through a shared decision-making approach that involves an open, honest exchange of information and values clarification, to arrive at a mutually agreeable decision about how to take collective moral responsibility for Sophia's care and well-being.[7-9]

Nurses' Roles and Responsibilities in Addressing Ethical Issues and Tensions

The role of nurses in addressing ethical tensions and issues was originally envisioned quite narrowly. Initially, most nurses were taught only about "role-based" or deontological (eg, duty-based) ethics; now, however, they are taught principle-based ethics (ie, principlism), including the ethical principles of respect for autonomy, beneficence, nonmaleficence, and justice. Today, although principlism is arguably still the dominant ethical theory nurses learn, it is no longer sufficient for defining the full scope of the ethical dimensions of nurses' roles. Nurses are moral agents, and as such they continually discern what is morally salient, including what moral matters are at stake and what harms or benefits could result from various courses of action, and they actively promote ethically optimal *ends* through morally defensible *means*. Although a valuable ethical theory, principlism alone is not sufficient to generate robust ethical solutions or to inform nurses' ethical practice. The field of ethics includes several other frameworks that receive less attention but can be immensely helpful in more fully understanding and addressing ethical issues such as those Sophia's family are experiencing.[10]

Multiple Ethical Lenses

In this column, we embrace the "multiple ethical lenses" metaphor[11] and integrative approach[10] by applying several ethical theories and viewpoints and showing how each yields a valuable and unique perspective on, and solutions to, ethical problems. Applying multiple ethical lenses can lead to a more comprehensive understanding of ethical issues and create a more comprehensive path forward than can strictly adhering to one theory, which may truncate understanding and unnecessarily curtail possible solutions for addressing issues. In particular, we highlight how nurses can use multiple ethical lenses to provide ethical care to their patients and families.

We also consider Sophia's particular situation through multiple ethical lenses, including principle-based ethics (principlism), narrative ethics, relational ethics, and virtue ethics. For each ethical approach, we provide a brief description, consider what it offers with respect to what ethical care for Sophia and her family comprises, and reflect on its specific attributes related to and contributions to integrative ethical nursing practice.[10] The Table summarizes the selected ethical approaches.

Principle-Based Ethical Lens

Arguably, the most well-known ethical framework in health care is a principle-based ethics (principlism), developed by Thomas Beauchamp and James Childress in 1979 and subsequently revised over the years.[12] Principlism seeks to balance 4 principles: respect for autonomy, beneficence, nonmaleficence, and justice. The first principle, respect for patient autonomy, requires that individuals be supported when making self-determining decisions without being coerced. Typically, autonomy is closely tied to the concept of informed consent—in health care, the process by which practitioners discuss potential risks and benefits of various treatment options and solicit from the patient a self-determinative decision regarding their preferences about those treatment options.[13,14] Patients may exercise self-determination by either accepting or rejecting treatments in accordance with their values. The second principle, beneficence, defines one's duty to promote an individual's good in some way. Nonmaleficence, the third principle, is somewhat related to beneficence and defines one's duties to refrain from causing deliberate harm, which itself is a stringent duty. Finally, the principle of justice requires that individuals receive what is owed to them, ensuring that costs and benefits are fairly distributed among individuals. Beauchamp and Childress[12] acknowledge that these 4 principles can—and often do—conflict in the moral life.

Autonomy. Principlism offers one lens through which we can analyze Sophia's case and arrive at decisions about how to move forward. Beginning with the principle of autonomy, we understand that because Sophia is an infant who cannot yet express her own

Table: Integrating Complementary Ethical Approaches Into Challenging Clinical Cases

	Principle-Based Ethics	Narrative Ethics	Relational Ethics	Virtue Ethics
Features	Focuses on identifying and addressing moral issues through consideration of 4 common ethical principles: autonomy, beneficence, nonmaleficence, and justice	Focuses on the patient's personal identity, meaning-making, and moral decision-making through the unfolding process of storytelling	Focuses on relationships as foundational basis for ethical concerns and for reconciliation of such concerns, as well as embodiment and emotional dimensions	Focuses on admirable character traits and virtues of moral agents, such as health care providers, rather than on moral actions per se
Applications	Use approach to capture major moral considerations, which are the starting point for ethical deliberation in practical cases	Use approach to uncover unique patient perspectives that can deepen and influence understanding, attitudes, behavior, and coping related to ethical concerns	Use approach to understand how the patient's experiences are relationally embedded and to identify how to work with these relationships to address ethical concerns	Use approach to highlight the range of positive character traits and virtues such as care, compassion, integrity, respectfulness, trustworthiness, courage, wisdom, and humility
Actions and Outcomes	Serves as a prevalent, familiar ethical approach Draws upon ethical theory to offer an approach to identify, describe, and address practical ethical issues Suggests the balancing of ethical demands facing patients and health care providers	Slows down and deepens information-gathering process Facilitates perspective-taking and reflection Brings forth and prioritizes the patient's voice and perspective Generates customized solutions to ethical concerns	Helps highlight a broader ethical scope in situations Promotes more family-centered approaches (rather than individualistic autonomy-oriented approaches) Clarifies ways in which health care providers are relationally involved in presenting ethical concerns	Emphasizes cultivating and adopting positive character traits and virtues of the "ideal" health care provider Promotes and deepens health care relationships Offers a life-long aspirational approach to personal and professional development and allows human flourishing

preferences and opinions, her parents serve as surrogate decision-makers, making on Sophia's behalf health care decisions that are in her best interests. Should Sophia's parents make a decision that they perceive to be in her best interests but that others perceive as risking likely or serious harm, parents' decisions and involvement in decision-making could be challenged. Ideally, however, Sophia's parents and her health care team would collaborate to make decisions for Sophia and would agree about what constitutes her best interests. In this case, such agreement was challenged when Sophia's parents overheard the team's perspective on Sophia's case, by their growing sense of being misinformed, and by their sense of being judged. As surrogates, Sophia's parents signed informed consent, granting permission for Sophia to undergo surgery. During this informed consent process, the health care team should have offered a thorough explanation of the potential risks and benefits of this surgery; from the principlist perspective, however, it seems that Sophia's parents have been unable to sufficiently consider, with respect to their values, the potential risks and benefits of their daughter's treatment options because the health care team was not fully transparent when explaining them. Sophia's case indicates that her parents did not receive a complete picture of what the VEPTR surgical procedure entails, at least over the long term.

Beneficence and Nonmaleficence. In considering what constitutes beneficence and nonmaleficence for Sophia, we note that her parents are not in agreement about how to move forward. Although both parents signed informed consent and agreed to surgery, Sophia's father is more optimistic about its

potential long-term outcomes and considers the good it could achieve as worth the potential risks. Sophia's mother, however, is concerned that Sophia may be suffering and is not convinced that performing a surgery with unknown outcomes will be good for her daughter in the long run. Furthermore, Sophia's parents and the health care team are beginning to have conflicting views around what constitutes doing good and preventing harm. Sophia's parents feel judged in their assessment that an uncertain treatment might hold some good, particularly because some members of the team disagree and some, particularly the nurses, do not consider the potential surgical result as a "good outcome," but rather as a weighty harm. The team did not, however, fully articulate the potential harms—which would have allowed Sophia's parents to make an informed assessment of what beneficence and nonmaleficence would entail for their daughter.

Justice. In addition to having their own views about Sophia's best interests and what constitutes doing good and not doing harm, the members of Sophia's health care team, according to a principle-based ethic, must consider how justice might be accomplished in Sophia's case. Specifically, the team needs to prioritize balancing the health care resources Sophia needs with those required by other patients in the PICU. Performing an uncommon, as-yet-unproven surgery typically requires additional staff and uses extensive equipment and resources, which can impact the function of the PICU as a whole. Ensuring that Sophia receives optimal care, although a priority, should not come at the cost of other patients receiving suboptimal care and resources.

Balancing the Principles. In particular, the nurses, as members of the health care team who spend large amounts of time directly caring for Sophia, might struggle with how to balance the 4 principles of autonomy, beneficence, nonmaleficence, and justice. As we mentioned, Sophia's parents' understanding of Sophia's best interests has conflicted with the nurses' understanding of what it means to "do good" and "do no harm" to Sophia. Sophia's nurses may also observe disproportionate resources being funneled to Sophia during and after the surgery, drawing resources and staff away from other patients. A principle-based ethics does not necessarily offer a means by which to resolve these conflicts. Ideally, the nurses could gain input from other resources such as hospital-based bioethics services to help them fulfill their ethical mandate to care for Sophia in the midst of these conflicts. But the nurses may experience considerable moral distress throughout this process. Indeed, Milliken and Grace[15] consider experiences of moral distress to illuminate likely sources of unresolved ethical tensions and dilemmas. When ethical issues can be adequately recognized, named, and addressed in clinical practice, the process can improve patient care, ease moral distress, and enhance adherence to professional ethical standards such as the Code of Ethics for Nurses.[16]

Narrative Ethics Lens

Another lens, the narrative ethical approach, focuses on personal identity, meaning, and moral decision-making through eliciting and understanding unfolding stories.[17,18] Whereas clinical ethics consults typically focus on dramatic, pressing questions of *what* to do and the urgent need to generate recommendations, narrative ethics steps back from this directness and focuses, through stories, on the *how* of the patient's situation.[18] Questions of particular interest in narrative ethics are *how* the patient arrived to their current situation and *how* the patient/family envisions moving forward. Montello[18] describes "mattering maps" as a valuable narrative tool; these are based on stories and help to discern what matters most in the patient's life and what an acceptable resolution might look like. In narrative ethics, resolution is akin to moving from a state of dissonance, perhaps precipitated by a serious diagnosis or worsening illness, to a state of relative consonance. Narrative consonance, or resolution, involves revising one's story and moral decision-making approach by considering the unexpected realities of illness. What matters most in this process is providing patients or surrogates—in this case Sophia's parents—with opportunities to hear themselves tell their stories, to reflect on what they are saying, and to come to some resolution about a version of their story they can live with under the circumstances. Defining features of narrative ethics include focusing on reconstructing patients' stories and lives, despite the rupture of diagnosis and illness, and helping people become capable of "new imaginations" of themselves and what they must do in order to live fully and authentically.[19]

Parents' Narrative. When given the opportunity to tell their story unhurriedly, consistent with a narrative ethics approach, Sophia's parents were eager to share their perspectives and through this sharing become less emotionally burdened. The couple grieved after a previous miscarriage, and they were understandably anxious about losing Sophia. Sophia's parents, upon learning of Sophia's prenatal diagnosis, grieved again and "got stuck on the word *asphyxiating*" that is associated with Jeune syndrome. Sophia's parents currently describe themselves as "fiercely" devoted to Sophia and feel it is important that she have the "best life" possible. Parenting in the context of Sophia's prolonged hospitalization and uncertain outcome has been enormously stressful; her parents struggle and have been overwhelmed as they assert themselves to make the "right" decisions and be good parents under the circumstances.[20,21] Sophia's mother has been pumping breastmilk, which she calls "white gold," but she is discouraged because she has not been able to breastfeed Sophia given the baby's postoperative challenges. Sophia's father has come to the hospital by himself recently because her mother is "tired" and finds it stressful when the team makes rounds. This altered pattern of parental involvement is a potential "red flag" that can alert nurses to underlying ethical issues and can, through gentle inquiry and narrative storytelling, serve as a springboard to more deeply unpacking and understanding those issues.

As their story unfolds, Sophia's parents question whether the surgery is "worth it." Initial descriptions of the surgery seemed promising, but they wonder whether they might have "rushed into things." Doubt and worry are taking their toll on the couple. Sophia's mother worries that the surgery and hospitalization are sacrificing Sophia's "precious babyhood" and their time as a new family. She also worries that the surgery will cause Sophia pain and suffering; this idea is difficult for her to bear because she feels helpless to protect her baby. Sophia's father, on the other hand, has convinced himself that the surgery is "insurance for the future" and could protect Sophia from further respiratory compromise. Tension grows between Sophia's mother and father regarding what they each believe may be best for Sophia.

Sophia's parents overheard the team's reservations about the surgery and their references to previous patients who "didn't do so well," which amplified tensions and planted seeds of mistrust toward the staff. They now understand that the surgical and nursing teams have differing opinions about pursuing the surgery, and they feel "caught in the middle." Although Sophia's parents are grateful for the care the team provides, they find it difficult to open up and fully trust the staff and feel judged, and they are uncertain about how to raise their concerns. The depth of the family's distress is revealed through their storytelling, indicating the need for more accurate information and reflection about the range of potential surgical outcomes in light of the family's values, assessment of and attention to Sophia's possible experience of pain and suffering, support for breastfeeding, and the chance to repair communication and family-staff relationships. On an organizational level, the case brings to light the need for staff to constructively discuss their divergent perspectives, recognize moral distress, and determine what is in the child's best interests, such that the team can both present a united approach and respect the family's values and perspective.[22] Moreover, the team might consider providing referrals to the pain treatment service, a lactation consultant, a social worker, and perhaps the palliative care service in order to more fully support the family.

Reflections on the Nurses' Narrative. The narrative approach, encouraging storytelling and "thick" descriptions of the parents' personal experiences, can be woven into nurses' assessments and everyday conversations at the bedside. Zizzo et al[10] explain how the narrative approach can offer a "non-expert formulation" of ethical challenges and a comprehensive outlook on the patient and the situation. For Sophia's parents, an exchange with nursing staff through narrative storytelling can create a safe, open space for them to reveal that they overheard the staff's conversation and their dawning realization that the surgery they have authorized for Sophia is perhaps more controversial and may be less successful than they originally understood. The parents can then share their fears that someday their daughter might be considered "another one of the failures." Such candid discussion can help nursing staff to understand alternate viewpoints, confront assumptions, be a

catalyst to initiate a resolution of intrateam disagreements,[22] and facilitate future meetings with the family wherein they jointly consider Sophia's situation and her best interests. The narrative approach slows and expands the conversation beyond mere sound bites, enabling parents and staff members to better understand and respect each other.[17-19] Such conversations can also lead to nurses having a heightened awareness of their ethical practice,[23] such as recognizing the power of their words and opinions, how easily they can be overheard and unknowingly unleash doubt and emotional distress on families, and how, instead, they can carefully uphold confidentiality.

Relational Ethics Lens

A turn to relational ethics can shift yet again how we imagine the ethical dimensions of Sophia's situation and what ethically attentive nursing practice should entail. Relational ethics is an ethical framework that arose within feminist ethics.[24] Feminist ethics developed within bioethics and beyond, to some degree in response to dominant ethical approaches (such as principlism) that are centered on individualistic conceptions of autonomy and the subsequent fragmentation of the physical and experiential dimensions of one's encounters with illness. Rather, a relational ethics framework advances conceptions of a person as a relationally engaged agent existing within webs of meaningful relationships with others that help shape their understandings of "good" and "bad." A person is understood to have moral aspirations and to be mindful of and capable of fostering their own well-being and that of others. This conception of a person as a moral agent applies to everyone who comes together in any health care situation: the patient, family members, health care providers, managers, and others. As a person navigates the moral terrain of their illness within their surrounding relationships, their decisions and courses of action are influenced by the surrounding sociocultural context. The literature evidences ever-growing recognition and support for how agency can be related to young children and infants.[25] Moreover, from a relational ethics perspective, a person is understood as being an *embodied* irreducible whole that integrates dimensions of their personhood, including the physical, psychological, social, and spiritual dimensions.[26] Understanding a person's encounters with illness—whether as patient, family member, or health care provider—involves focusing on the lived *embodied* experiences of patients, even infants and young children, as they strive to fulfill their moral aspirations or goals. The quality and impact of a person's immediate relationships and the societal relational context of the broader community can either bolster or thwart this natural striving when faced with illness or adversity.[27]

Relational ethics, a broad moral framework, has had significant traction within nursing ethics, as many nursing scholars have argued that a relational view of the moral dimensions of nursing is strongly congruent with the dominant values and viewpoints of the profession.[24] Some nursing ethicists have adopted relational ethics and developed it into more detailed models to guide ethical practice in nursing. For example, Oberle and Raffin Bouchal[28] developed a relational ethics model specifically for nursing practice; it is structured along 5 principal "steps" that can guide ethical care of patients and their families: (1) assess the ethics of the situation (relationships, goals, beliefs, and values); (2) reflect on and review potential actions (recognize available choices and how those choices are valued [advocacy]); (3) select an ethical action (maximizing good); (4) engage in the ethical action; and (5) reflect on and review the ethical action.

Experiences of Sophia and Central and Interested Agents. Given that concerns exist about Sophia's quality of life and her possible current and future suffering, and drawing on relational ethics and Oberle and Raffin Bouchal's model,[28] it is important to explore how Sophia's daily experiences and primary relationships can be effectively assessed and understood. This involves understanding Sophia's favorable experiences, such as comfort and happiness; her unfavorable experiences, such as suffering and distress; and the impact of clinical practices and surgical interventions on these experiences. It is particularly important to consider how daily clinical practice and the VEPTR surgical intervention might promote her "best" interests. An appraisal of Sophia's experiences as a young infant will necessarily require input from central people who are in a relationship with her, who provide care, who may have special insights into her physical and emotional expressions, and who can help interpret what is "good" and "bad" for her. Sophia's experiences are relationally embedded; they are not enacted in an

experiential vacuum. Rather, she is enmeshed in many relationships and is valued as a daughter, granddaughter, "baby cousin," and "little neighbor." Parents and family members of children—and the clinical staff working closely with children such as nurses and child development specialists—can serve as valuable "interpreters" for children, whose experiences may be difficult to understand, as can determining how best to act on them. Relational ethics, however, also entails a regard for the experiences of others involved in a situation. Sophia's care and her experience affect others such as her parents, grandparents, and the clinical staff working with her. Although Sophia's best interests should be paramount in determining the most appropriate course of action, the interests of others should also be identified. Surrogates and health care professionals should address, to the extent possible, the potential impacts of various courses of action while being mindful not to subordinate Sophia's best interests, as she is likely the most vulnerable person in this situation.

Sophia's mother notes that Sophia likes to be held gently and "cuddled," and to watch her musical giraffe mobile when she is sufficiently comfortable. For her part, Sophia's mother describes deep joy and relief in feeling that Sophia "knows a mother's love" and that she can experience some typical baby activities when she is not feeling discomfort. Sophia's father notices that Sophia seems to be most comfortable when she is positioned semi-upright and has her bed oriented toward the window. For his part, Sophia's father describes feeling like he is "doing his job" when he does the "little things" that make her more comfortable, and when he participates in rounds with the team and understands Sophia's plan of care and how she is growing.

The nurses involved in Sophia's care have developed relationships with Sophia and her parents, and within the larger team they fulfill many roles—care provider, advocate, educator, liaison—depending on what the relationship requires. The nurses may be conflicted and morally distressed when implementing the current treatment plan, perhaps feeling as though they are perpetrating harm. As nurses perform interventions that can be very uncomfortable for Sophia, they may feel as though they are betraying their responsibility to promote her well-being. A relationally attuned ethical analysis can help ensure that the concerns of all "interested agents," including the nurses who frequently care for Sophia and have a relationship with her parents, are adequately considered and integrated into the clinical action plan. Nurses, practicing as moral agents, must actively participate in these analyses to ensure that their perspectives on Sophia's experience, and on how different interventions favorably and unfavorably affect her care, are thoughtfully considered during clinical discussions and treatment planning. Likewise, nurses should contribute their views on the parents' experiences and how various approaches to care might affect them.

Virtue Ethics Lens

Virtues are considered to be the most ancient, durable, and ubiquitous of concepts in the history of ethical theory.[29] Virtues are understood as deeply entrenched, morally good and commendable character traits that make a person morally reliable and virtuous. Virtue theory emphasizes positive character traits and virtues including care, compassion, respectfulness, discernment, trustworthiness, integrity, wisdom, courage, humility, conscientiousness, and commitment—all of which promote caring and caregiving.[12,29] Virtue ethics can offer nurses and other health care providers a steadfast, aspirational, enduring basis for their actions, for example, being truthful, respectful, and conscientious in relationships with patients, families, and colleagues.

Virtues matter deeply in health care settings such as the PICU, where trust, intimacy, and dependency are vitally important and highly valued.[12] Virtues enable each practitioner to discern what action he or she should strive toward and be motivated to do across a range of circumstances, without the need for preexisting rules.[12] Admirable virtues such as integrity and respectfulness bode well for establishing and upholding positive patient-provider relationships, which are central to high-quality health care. Virtues are particularly relevant in critical care settings because unexpected dilemmas can arise, and positive enduring values can serve as one's moral compass. Although critics have claimed that virtues are unwieldy, outdated, and too difficult to implement and measure, virtues and virtue ethics have experienced a resurgence in the context of modern-day health care.[12]

Compared with a utilitarian ethical approach that demands the greatest good for the greatest

number, or a deontological ethical approach that is based on duty and grounded in reason, virtue ethics focuses on the moral agent, or the person who is exercising moral judgment and ethical behavior, rather than on the act itself, and on the person's character and motivation, rather than on their conduct.[30] Virtue ethics posits that the *character* of a health care provider is more important and enduring than their conformity to obligation-oriented ethical rules, and that society should place a premium on cultivating virtues through role modeling and education. Virtue ethics prompts each health care provider to consider what virtues the ideal virtuous person—or in this case, the ideal virtuous nurse—has and how those virtues should be implemented. Virtue ethics is well suited as a foundation for professional ethical standards and conduct, and some clinicians advocate for restoring virtues as a vital guiding force in professional ethics.[29]

Virtues in Sophia's Situation. Several "ideal" virtues come to mind for health care staff caring for Sophia and her family: integrity, honesty, truth-telling, compassion, and moral courage. Given the unfolding circumstances in which Sophia's parents are questioning whether the health care team has fully disclosed all information about the VEPTR surgery, whether they were truly informed when they gave consent, or whether they made the best decisions on Sophia's behalf, the overarching virtue of integrity would guide nurses to be true to their sense of what is right and wrong, and to seek to do the right thing on behalf of the child under their care. In this situation, it would be imperative for nurses, individually and as a team, to step forward with integrity and honesty in order to ensure that the family understands the range of views about the surgical intervention. Honestly and respectfully sharing one's observations and perspective on behalf of the patient and her family can advance family-staff dialogue and promote optimal care. Indeed, a full rendering of the situation—the potential challenges and outcomes of Sophia's surgical plan of care; insights into Sophia's lived experience as a patient; and perspectives of the surgeons, nurses, team, and family—would be most beneficial, restoring trust within the team and between the team and parents, and would provide peace of mind for Sophia's parents.

Contributions from virtue ethics can be personally and professionally motivating and aspirational, and can support the ongoing cultivation of self-reflective practice, respectful communication and interpersonal characteristics, and professional nursing development. Zizzo et al[10] argue that virtue ethics can heighten the attention and capacity of excellent, virtuous clinicians such as nurses to exercise sound judgment of their patients' best interests based on a generous, charitable understanding of and significant engagement with the patient's and family's values. Practically, virtuous clinicians are called upon to display excellent listening skills, with the intention of truly understanding the patient and their colleagues rather than listening in order to merely agree or disagree. It follows that virtuous clinicians thoroughly consider others' perspectives, refrain from interrupting or speaking ill of others, and recognize that one may hold alternate views and disagree but should not be disrespectful. Given the unfortunate circumstances of Sophia's parents overhearing unexpected criticism of the surgical treatment plan and a breach of confidentiality, nurses committed to the process of becoming more virtuous would probably sincerely apologize and reach out to surgical colleagues to convene a family-staff meeting where differing opinions can be shared respectfully and with integrity—all with the intention of honoring Sophia's parents' values and working toward consensus about what is in the child's best interests. In this spirit, the nurses and other clinicians can ask themselves whether their interpersonal sensibilities and skills are sufficiently developed to enable patients (and fellow staff) to express themselves freely and to feel comfortable doing so.[10] Thus, virtue ethics provides a framework for identifying worthy aspirational character traits and for committing to the lifelong process of enhancing these traits during everyday encounters, striving to become ever more virtuous in the service of patients and their families.

Conclusion

Embracing an approach that applies multiple ethical lenses in critical care settings can promote a more nuanced, comprehensive ethical analysis and lead to more robust ethical action. Each of the ethical approaches discussed here has distinct features and allows one to consider challenging cases like Sophia's. When considered together, these lenses offer greater perspective and ethical understanding than

any one individual approach alone. The principle-based approach (principlism) grounds nurses in the familiar, foundational ethical principles of respect for autonomy, beneficence, nonmaleficence, and justice. The narrative approach encourages deep appreciation and understanding of the patient's and family's perspectives and lived experiences through unfolding personal stories. The relational approach prompts nurses to be attentive and responsive to the network of relationships through which patients and families can be understood and meaningfully cared for. The virtue approach speaks to admirable character traits that clinicians may aspire to and cultivate throughout their professional careers, including compassion, respectfulness, trustworthiness, and integrity—all of which promote excellence in nursing care. Considered together, these approaches can raise ethical awareness among critical care nurses, expand their repertoire of skills and relational abilities, and guide ethical practice.

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2. Identify the value of using multiple ethical frameworks when analyzing the ethical aspects of a clinical case.
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