Enhancing Moral Agency:
Clinical Ethics Residency for Nurses

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Prior to participating in this program I reacted to ethical problems on a highly emotional level. When analyzing an ethical problem using my own values as a backdrop, my reaction became very personal. By using the skills I have learned over the past 9 months, I am now better able to separate my feelings and values from the problem and look more objectively at the views of all parties involved. In fact, some of the situations I may have considered to be ethical problems in the past look quite different now.
— A CERN program participant

Nurses' beneficent motivation for patients and their surrogates is routinely tested. More than other professionals, nurses have intimate access to patients' subjective and objective experiences in inpatient health care institutions.[1] Nurses abide with patients in the progression, remission, and cure of disease. During the trajectory of an illness, all interventions that the patients receive are provided by or in the presence of nurses, and nurses care for, monitor, and assess patients' responses to these interventions around the clock.[2] Sometimes this responsibility becomes onerous, as the many obstacles to good nursing practice give rise to moral unease or distress, distancing from patients, and attrition from the profession.[3]

One antidote to moral distress is stronger moral agency—that is, an enhanced ability to act to bring about change.[4] The Clinical Ethics Residency for Nurses, an educational program developed and run for nurses from two large northeastern academic medical centers and their affiliates with funding from the Health Resources and Services Administration, intended to strengthen nurses' moral agency. Drawing on *Improving Competencies in Clinical Ethics Consultation: An Education Guide*,[5] by the American Society for Bioethics and Humanities (ASBH), and on the goals of the nursing profession, CERN sought to change attitudes, increase knowledge,

and develop skills to act on one's knowledge. One of the key insights the faculty members brought to the design of this program is that knowledge of clinical ethics is not enough to develop moral agency. In addition to lecture-style classes, CERN employed a variety of methods based in adult learning theory, such as active application of ethics knowledge to patient scenarios in classroom discussion, simulation, and the clinical practicum.

Overwhelmingly, the feedback from the participants (sixty-seven over three years of the program) indicated that CERN achieved transformative learning. Participants' comments included, for example, the following:

> The CERN program has been the most meaningful class I have taken. It has made such an impact on not only my nursing care, but on myself as I interact day to day with others.

> I use this course everyday [*sic*.] now. . . . I feel much more confident in my ability to navigate through sticky situations . . . . [I]t's not that unethical behavior doesn't bother me (anymore) but I know how to deal with it.

> My peers now look to me for support. We are able to problem solve faster and more efficiently.

> I expected to increase my knowledge of ethics consultations and dilemmas, but what I got was a renewed way of approaching my patients and families.

In the following, we lay out the underlying rationale for this program, its structure, and content. We provide evidence of its success from evaluation data to highlight its significance for patients, families, peers, and allied health care providers.

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Literature Review and Innovation

The underlying assumption of the project was that developing nurses' moral agency—their capacity and willingness to act on behalf of the patient's and family's good—was possible and desirable and would influence practices within the primary institutions served by the residency program. We had the goals and code of ethics of the nursing profession and ASBH's *Improving Competencies* blueprint to guide focus and content,[6] but we needed to know best practices related to developing nurses' (and other health care providers') ethical decision-making capacities, ethical confidence, and willingness to act to resolve emerging and actual ethical problems. We also knew from the literature that reinforcement and supportive environments are required to sustain moral agency over time. We surveyed the literature to find out what ethics education programs existed, how effective they were, and whether they addressed the aims of our project. For developing the qualities of ethically confident nurses, we relied both on James Rest's empirically based description of the cognitive processes underlying moral reasoning and on insights about human cognitive biases and limitations from John M. Doris and colleagues' critical analyses of knowledge developments in the discipline of moral and cognitive psychology.[7] Rest's model proposes, based on an extensive review of extant research, four interrelated processes that have to occur in the mind of someone who carries out a moral action. These "four major [processes or] components must be considered in developing a moral framework: (1) how does the person interpret the situation and how does he or she view any possible action as affecting people's welfare; (2) how does the person figure out what the morally ideal course of action would be; (3) how does he or she decide what to do; and (4) does the person implement what he or she intends to do?"[8] Our program needed to address all of these elements in developing and sustaining nurses' moral agency and leadership.

Rest's component 1 is the idea of *moral sensitivity*. As Rest notes, it "involves the perception that something one might do or is doing can affect the welfare of someone else either directly or indirectly."[9] Moral sensitivity is the capacity to grasp the ethical nature of situations.[10] For nurses, this means, among other things, understanding the inherently ethical nature of all nursing situations and all nursing action. The actions of nursing are aimed, directly or indirectly, at achieving a good for the patient or family and thus are subject to ethical appraisal. However, many nurses lack

confidence to advocate for a patient when barriers to meeting the patient's needs exist.[11] Moral sensitivity is enhanced by education, self-reflection, reflection on practice, discussions involving diverse perspectives, good role models, and effective mentoring.[12] Educational strategies conducive to the development of moral sensitivity include journaling,[13] guided case analyses, role-play, simulation,[14] and discussions with others who have diverse perspectives.[15]

Component 2—determining the morally ideal course of action in a nursing and health care professional context—requires guided practice in processes of decision-making. The ingredients of moral decision-making include aspects of component 1 plus a capacity to analyze a situation using knowledge of ethical thinking and language, knowledge of historical precedents, clinical knowledge, knowledge of the patient and the patient's context, and an understanding of the unit and institutional environment and the available resources. Communication skills are also needed for gathering adequate and appropriate information to make an informed decision.[16] However, evidence about best educational methods to achieve these goals remains either scant or narrow in scope.

Component 3—deciding what to do—requires imagining what should and can be done, imagining how one will act, and practicing this behavior. We relied on a reflective practice model of case discussion and role-play as well as what we came to call "checking in," which occurred at the beginning of each education day as well as spontaneously throughout the program, to develop participants' moral agency.[17] The reflective practice provided participants the opportunity to practice how they would access resources, what they would say, and how they would use ethics language to discuss and explain their considered perspective on the problem to colleagues. Actual clinical ethics cases, modified to maintain patient confidentiality, were used to design discussion exercises and to create role-play opportunities, using "fishbowl" and video playback strategies, both of which allow the participants to observe and critique their own and others' communication in groups.[18] The fishbowl strategy allowed those who were not participating in the role-play to observe those who were enacting the roles in the case designed for role-play, as one might observe the goings on in a fishbowl. Conversely, the video playback strategy allowed participants and observers to view together the enacted role-play. These pedagogical methods created a low-risk environment to discuss ethical problems, receive feedback from faculty and colleagues, and build empathy and appreciation

of others' perspectives. The checking-in portion of each day gave participants an opportunity to recount how they had used their developing skills in their clinical setting. Examples included advocating for the patient's or family's perspective during interdisciplinary rounds, contacting the attending physician with concerns about the goals of care for a patient, and interrupting the momentum toward resuscitating a terminally ill patient.

Component 4—persevering to do the right thing and to continue developing—was and is addressed through the clinical mentorship component and postprogram continuation sessions. Shadowing and mentoring opportunities helped the participants to see "ethics in action," as demonstrated by the nurse ethicists at each institution. These opportunities provided evidence of effective actions to promote the patient's and family's good, and they enhanced participants' own skill development.[19] Ongoing quarterly continuation sessions bring together participants from the cohorts of all three years of the program. These sessions are two-hour meetings in which cases are reviewed and skills are refreshed. Continuing education is recognized as important in reinforcing ethical sensitivity, motivation to act, and moral agency.[20]

In designing the program, we relied on the idea that health care environments are subject to change and influence and that ethically competent nurses can help make an institutional environment conducive to good patient care. The ongoing quarterly sessions help to sustain interest, skill development, perseverance, and a supportive community. Before developing our model, we had unsuccessfully searched the literature to find a method of ethics education that would meet the broad identified needs of point-of-care and supervisory nurses. A plethora of educational initiatives and strategies was discernible in the literature, but none of these was comprehensive enough to address both the affective and cognitive elements that we saw as necessary to develop ethically confident nurses who could serve as local ethics resources for their peers.

Description of the Intervention

The overall goal of CERN was to increase the number of nurses who have knowledge, skills, and competencies in clinical ethics and who can use those attributes to impact patient care. CERN was designed to develop clinical ethics competence by bridging concepts of moral philosophy, professional nursing ideals, ASBH curriculum, and participants' clinical practice. Adult education models hold that what is learned needs to be useful, applicable, and effective. CERN was designed to incorporate specific ethics content and experiential learning, melded with participants' clinical experiences, to motivate participants to act effectively to address emerging or potential ethical issues. From the literature, we knew that an effective program would need to address attitude, values, knowledge, and communication skills and provide opportunities to apply these in the interests of prevention, early identification, and interventions to resolve real clinical ethical problems.

The program, using the educational methods discussed below, aimed to train participants to recognize the feelings of unease they experienced in practice situations and to examine those feelings from an ethical perspective in order to effectively address the situations in which they arose. An additional aim was prevention—that is, attempting to prevent the problematic situations from arising in the first place. We believed that the development of a cohort of ethically competent nurses would result in the overall medical team's enhanced ability to recognize emerging problems. Ultimately, nurses with the capacity and confidence to influence the environment on behalf of good patient care should be able to contribute to positive patient outcomes. CERN offered a solid overview of conceptual ethics understandings, knowledge of professional responsibilities as outlined in the nursing literature, including the *Code of Ethics* of the American Nurses Association (ANA), and practice through case simulation. Developing effective communications skills was a critical component of the program. Participants also received mentorship in applying knowledge and skills, and they prepared to take leadership roles in identifying and resolving recurring ethical issues in their clinical settings.

CERN involved two levels of nurses: point-of-care or staff nurses and advanced practice or supervisory nurses. Staff nurse development was aimed to increase nurses' capacity for timely detection of emerging problems and initiation of preventive actions for frequently encountered ethical situations. The focus at this level was preparation to lead unit-based ethics rounds and serve as local ethics resources to colleagues. At the supervisory and advanced practice level, many nurses had master's degrees and leadership responsibilities, and the aim was to prepare them to participate in hospital-wide ethics leadership and consultations. The two levels of nurses attended classes together, but the differing skills were emphasized in the postclass mentoring activities. At either level, the expectation was that, at the completion of the program, the nurses would be able to address ethically difficult situations by advancing the discussion or initiating communication and collaboration and by accessing or developing resources.

As noted, a variety of pedagogical approaches was used, based on Rest's four-component model. The result was a ninety-eight-hour program spread out over ten months. First, all participants took an online, two-hour-long foundations of ethics course. Following that, they participated in a series of ten eight-hour classroom days, approximately one per month (for a total of eighty hours). These class days included lectures, role-play, and high-fidelity simulation. Additionally, there was an out-of-class clinical mentorship component (sixteen hours). Optional continuation sessions, to which each year's graduated cohort were invited, are offered quarterly, with the aim of reinforcing learning and providing peer support.

Foundations of ethics course. A two-hour, online program developed by the authors and administered through a web-based learning platform was required of participants prior to the first day of class. The content of the program addressed theoretical components in ethical discourse, including the

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four well-known major ethical principles, care ethics, virtue ethics, the ANA's *Code of Ethics*, and case studies. The educational objective of the online program was to familiarize, or refamiliarize, participants with the concepts on which the program would then build.

CERN classroom. The faculty integrated the ASBH educational guide content with nursing's professional goals as articulated in the ANA's *Social Policy Statement* and *Code of Ethics*. The faculty members' experience in theoretical and clinical ethics allowed them to help participants apply ethical frameworks to clinical cases. Each topic required preparatory reading assignments posted on a web-based learning platform. Topical objectives and detailed slides were prepared as handouts and distributed on the day of the specific topic.

Initial content focused on the theoretical aspects behind applied ethics and its associated language. Next, approaches to the recognition, clarification, and analysis of ethical problems were introduced. We used the frameworks proposed by Ruth Purtilo and by Al Jonsen and colleagues for problem discussion.[21] Once the language and frameworks of ethical analysis were introduced, along with cogent case examples, we introduced various clinical ethics domains that occur within the acute care clinical area. Among the topics covered were end-of-life decision–making, transplantation, medical futility, research ethics, and social justice issues. Some guest speakers presented on specialized topics, such as the legal standards that influence ethical decision-making and genetic counseling. Supporting empirical data available on a given topic were integrated into the lectures. Lectures were presented by one of the faculty members, or at times by a guest speaker, and served to provide new information, clarification, or assistance to participants in developing their thinking.

Values exploration. Early on in the classroom, an important part of the program, in line with Rest's Component 1 and Doris and colleagues' insights from moral psychology, was an exploration of the participants' own values and their influence on action. Professionals need to be able to recognize the powerful emotions inherent for any stakeholder in an ethically worrisome situation and the values and biases that are likely to be in play.[22] In order to facilitate objective, effective, and intentionally appropriate ethics leadership, self-awareness of the core personal values that influence professional functioning is both a necessary first step and an ongoing goal. Therefore, the very first day of CERN offered opportunities for reflection and growing self-awareness of each participant's core values. An interactive lecture opened

the space for reflection on family-of-origin experiences and roles that may have motivated or influenced participants' professional roles. The goal was to begin differentiating past family-of-origin roles from current professional roles. Questions to stimulate reflection aimed at nurses' earliest experiences of taking care of another person. Participants were invited to remember relationships and events in which they learned to be compassionate, caring, and "good." Insights led to greater understanding of how each nurse's early relational experiences might have helped form his or her moral reasoning in current clinical contexts. Introducing the concept of "covenants"—relational trade-offs activated in relationship to key family members, parental figures, or the family as a whole—allowed reflection on what was morally unacceptable or especially encouraged to maintain essential relationships. Additional reflection also led to insights about the potential costs of such relational trade-offs. Participants were free to share their thoughts or to work along silently, but either way, they were invited to discover old and new choices in professional caregiving relationships.

Ongoing reflective time. Built into the start and close of each day was a thirty-minute reflective period, or "checking in," during which participants shared "learnings" and how they had applied their developing skills. Evident in these reports were examples of moral agency and even moral courage on behalf of patients.

Communication techniques. In any ethically difficult situation, those who lead the exploration need to ensure that the various modes of communication have been effective. Ethical issues can be caused or exacerbated by miscommunication, can elude analysis because communication has not been effective in eliciting needed information, or can cause antipathy among members of the team. CERN participants were therefore introduced to a communication tool that analyzes verbal interaction. SAVI, the System for Analyzing Verbal Interaction, offers a systematic, objective approach to assessing what works in ethics conversations and what may not work.[23] SAVI is centered on methods of communicating that increase the likelihood of transferring information accurately and effectively. The tool offers an analytic instrument to dissect the anatomy of ethics discussions. CERN focused particularly on three verbal behaviors that block successful verbal interaction: "yes, buts," making negatives predictions, and "mind reads."

The goal in using SAVI in teaching ethics competency was to facilitate the development of an "internal observer" in participants as they communicated about ethics issues, as well as

Table 1.
Demographic Characteristics of Participants

	M (SD)	Minimum	Maximum
Age	46.34 (11.47)	24	66
Years worked as a nurse	20.46 (13.04)	< 1	46
	N (%)		
Gender			
Male	5 (7.5)		
Female	62 (92.5)		
Race			
Black	2 (3.0)		
White	64 (95.5)		
Pacific Islander	1 (1.5)		
Ethnicity			
Hispanic	0		
Non-Hispanic	67 (100%)		
Role			
Staff nurse	46 (68.5)		
Advanced practice nurse	11 (16.5)		
Nursing leader	10 (15)		
Education			
Diploma/AD nursing	11 (16.7)		
BS nursing	36 (54.5)		
MS nursing	18 (27.3)		
PhD nursing	1 (1.5)		

facilitating the development of capacity to detect and potentially intervene in ineffective communication. SAVI concepts were introduced using the SAVI grid, which codes all verbal communication behaviors. Using the SAVI communication analysis, CERN participants became able to differentiate supposition from fact and emotions from data. In a training practicum and in subsequent applications of SAVI in ethics discussion, participants learned to become aware of emotion, both their own and that of others, while distinguishing emotion from ethical reasoning.

Role-play and simulation. While both role-play and simulation involved taking roles in a scenario, the simulation sessions were videotaped in a high-fidelity laboratory permitting post-hoc self, peer, and faculty review of the role-play and how it unfolded as a result of the various interactions. From the third day forward, and in part because of the limited availability of the simulation lab, the group was divided between role-play and simulation groups in the second half of the educational day. The two groups alternated each month between role-play practice in the simulation lab and classroom role-play scenarios. Role-play and simulation experiences constituted thirty-two hours divided into approximately eight four-hour sessions. Both role-play and simulation sessions used scenarios designed to reinforce the morning's didactic content and build on prior content and simulation experiences.

Case content for role-play and simulation lab practica included the use of anonymized cases that related to that morning's lecture content. The roles included physician, nurse, chaplain, social worker, family member, and ethics consultant. Nurse participants took turns playing these roles in a team or family meeting. Roles were particularized (with each role description containing details about personal or professional characteristics or both) and included directions about how to enact the role. Participants who had no assigned role acted as critical observers. Role-plays lasted about twenty-five minutes, after which those playing the roles were asked to share their experiences.

High-fidelity simulation practica were supervised by CERN faculty. Competency areas targeted for development included facilitating ethics rounds and conducting ethics consultation or acting as a resource to the care team. In the simulation lab, the group was videotaped as they enacted the role-play, enabling group and self-review facilitated by faculty. In both the simulation and the classroom role-play, faculty members led debriefing discussions at the end of each session. The goal of videotaped conversations was both for practice and for participants to become aware of verbal and nonverbal behaviors that were driving or creating barriers to discussion or resolution. Although both role-play and simulation lab practica could make participants nervous, the safety of the practice environment for participant experimentation and development was emphasized. We discussed criteria for maintaining group comfort and support, and we stressed that the ultimate purpose of these exercises was to facilitate their real-world capacity.

Clinical mentorship. Built into CERN was the opportunity to apply knowledge and skills gained in a clinical mentorship practicum. Sixteen hours of mentored practica were allotted, supervised by CERN faculty. By day five of the program, nurses were asked to begin seriously considering what they wanted from their clinical mentorship experience, and a faculty mentor was matched accordingly. Approximately 75 percent of the participants took advantage of a formal clinical mentorship experience, such as setting up an ethics rounds on their unit, creating an educational program for peers, and systematically applying communication techniques with intent in challenging cases.

Continuation sessions. Continuation sessions are optional quarterly meetings held for the purposes of supporting and enriching the ethical knowledge and skills of CERN graduates. At these sessions, the graduates have the opportunity to

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present challenging cases of their own and brainstorm strategies. The sessions are viewed as being critical to sustaining and extending the initial learning by focusing on recent clinical ethics events and topics.

Evaluation of the Intervention

Educational evaluation was designed to collect quantitative data on three specific outcomes: moral distress, knowledge, and self-efficacy, as well as qualitative outcomes such as moral sensitivity.

Sample. Divided into three cohorts over three years, sixty-seven registered nurses employed at two large academic medical centers in the northeast participated in CERN. The sample was predominantly female, white, and well-educated staff nurses (see table 1). Individuals were deemed eligible for the program if they were registered nurses who demonstrated motivation to learn and expand their knowledge and skills in clinical ethics, had two years of tenure in their institution, evidenced a commitment to attend all sessions, and had their leaders' consent for their participation. Interested individuals applied by responding to emailed and posted flyers announcing the program, and participants were selected by faculty based upon the merits of their application, which included a narrative describing their reasons for applying and their experiences in clinical ethics as applied to patient care. The sample was also selected to represent a variety of clinical specialties, such as maternal and child health, oncology, and intensive care. Attendance in CERN occurred during paid work time, and contact hours were also awarded. Informed consent was obtained verbally from all participants.

Setting. Two large northeastern academic medical centers, one of which was the Health Resources and Services Administration grantee, provided the setting. Both institutions have quaternary care hospitals located in an area of medically aggressive end-of-life care where these and other ethical issues are part of daily practice.[24]

Design. CERN employed a quasiexperimental design involving mixed methods. The design included pre- and post-testing, with testing ten months apart, and the mixed methods included both qualitative description of participants' experiences and quantitative measures of changes in skills, knowledge, and self-efficacy. Although we refer to the program as a "study," it might more accurately be described as the educational evaluation of a workforce development program.

Instruments. Three instruments were used. The registered nurse version of the Moral Distress Scale—Revised (MDS-R) is a twenty-one-item self-reporting instrument designed to measure moral distress among nurses.[25] Responses were recorded on a 5-point Likert scale ranging from 0 (meaning never or none) to 4 (very frequently or to a great extent). Participants were asked to respond twice to each empirically derived item, first concerning the *frequency* with which the situation occurred in their clinical practice, and second concerning the *level of disturbance* they experienced in association with it. The sum of the products (frequency times level of disturbance) ranged from 0 (zero) to 336, with higher scores indicating higher levels of moral distress.

The Ethics Knowledge Scale is a twenty-item self-reporting instrument designed by the authors to test participants' knowledge of the terms and principles of ethics. Participants were asked to respond to the items by selecting "true" or "false." Correct responses were worth 1 point, and incorrect responses 0 (zero). The summative scores ranged from 0 to 20.

The Self-Efficacy Scale in Clinical Ethics is a twelve-item scale designed by the authors to measure participants' confidence in meeting the identified competencies of CERN. As described by Albert Bandura, "Self-efficacy is the belief in one's capabilities to organize and execute the sources of action required to manage prospective situations."[26] Responses were recorded using a four-point Likert scale ranging from 1 (not at all confident) to 4 (extremely confident). Items in the survey asked about participants' confidence in their ability to, for example, describe the goals of a clinical ethics consultation, help the patient understand the implications of the medical prognosis for him or her, and discuss resuscitation options with families. Scores ranged from 12 to 48, with higher scores indicating greater self-efficacy.

Procedures. CERN participants were issued a personal identification number known only to themselves, a staff assistant, and the project evaluator. The faculty, managers, and supervisors never saw the PIN linked with any name. Once participants were issued a PIN, they were asked to complete the preintervention test just prior to taking the online course and later the post-test, using a secure, web-based survey platform. The postintervention data were collected two weeks after the last classroom day. Participants were also asked to write and submit narrative stories about the impact of CERN on their nursing practice. They were told that they would be invited to share their narratives with their class on day ten, the final day of CERN, and they consented to submit

narratives for thematic analysis by the faculty, with the understanding that data would be reported in the aggregate or by using pseudonymns.

Human subjects review. This study received approval from the Partners Human Subjects Committee after an expedited review. Although education evaluation does not normally require human subjects' protection, this added step was taken to enhance the overall quality and ethical conduct of the evaluation.

Data analysis. Survey data were downloaded from our web-based data collection platform directly into Statistical Package for the Social Sciences (SPSS, v. 18.0). Univariate descriptive statistics (measures of central tendency [means, medians, and modes] and dispersion [standard deviations] for continuous variables and frequency counts and percentages for categorical variables) were computed for all study variables. The majority of the data were nominal, and the continuous data were normally distributed. No systematic patterns of missing data were found. Preliminary data analyses were conducted after each cohort completed the CERN, and final analysis was conducted on sixty-seven participants at the conclusion of the project using a paired-samples t-test. We used the Bonferroni correction to adjust for multiple comparisons.

Impact on Participant Knowledge, Behavior, and Patient Outcome

In addition to the overall goals of CERN, the authors hypothesized that the program would decrease nurses' moral distress and increase their knowledge and self-efficacy in clinical ethics. The quantitative findings, displayed in table 2, support the hypothesis. A paired samples t-test conducted to evaluate the impact of CERN on participants' scores on the three measures showed a statistically significant decrease in moral distress, as measured by the MDS-R from time 1 (M = 72.04, SD = 33.59) to time 2 (M = 56.82, SD = 29.59) (t[49] = 4.23, p < .000). Participants also demonstrated slightly increased knowledge from time 1 (M = 15.34, SD =1.75) to time 2 (M = 16.23, SD = 1.92) (t [66] = -2.86, p < .005) and self-efficacy from time 1 (M = 27.75, SD = 5.87) to time 2 (M = 33.53, SD = 5.42) (t[64] = -8.7, p < .000).

In addition to quantitative findings, participants' narrative reports were solicited, and these reports also provided evidence supporting the authors' hypothesis.

Judith, a midcareer intensive care unit (ICU) nurse, demonstrated an increased moral sensitivity when she expressed,

[T]he issues have not changed, yet my perception and approach to these issues has developed a greater depth. I recently cared for a thirty-year-old Jehovah's Witness patient with an ulcerative colitis flare, whose blood count dropped to 12; in the past, I'd have been angry about the situation, knowing that basic medicine could alleviate this patient's problem, but now, I better appreciate and respect the patient's religious beliefs, even if such beliefs seem difficult in

the face of a condition that modern medicine could cure pretty easily. This shift allowed me to be truly present and supportive with this patient and his family in their heart-wrenching journey.

Sarah, a midcareer pediatric nurse, talked frequently in CERN about how difficult the "gray areas" of nursing practice were to her and about not possessing the communication skills to express moral distress about patient-care concerns. Through CERN, Sarah found a voice regarding her moral angst about an adolescent cancer patient population that requires multispecialty care but for whom surgical treatments can cause debilitating, lifelong effects, including bowel incontinence and paralysis. Sarah found a pathway to articulate her concerns to the ethics committee chairs, who arranged a meeting about this patient population that included surgery, oncology, psychiatry, nursing, medicine, social work, chaplaincy, and rehabilitation professionals. She reported,

Interprofessional dialogue at the meeting was respectful yet forthright, and led to many creative ideas that were adopted as "quality improvements" in the processes of care for this patient population. A year later, teams are working more effectively together, with disciplines having greater appreciation for one another's contributions and challenges. Patients and families are receiving care that is now highly coordinated, and with the systematic addition of two additional services that can impact their quality of life in a substantive way.

Peter, an experienced emergency department nurse, credits CERN with giving him more effective moral agency in an intense clinical situation, ultimately affecting the patient's outcome. When an older, terminally ill woman who had been home on hospice was taken by ambulance to the emergency department because the daughter had called 911, medicine, nursing, and respiratory were poised to intubate the patient. In his narrative report, Peter recalled saying, "Wait. Let's think together about this. Perhaps this family panicked." The physician agreed, and more information was quickly gleaned from the electronic medical record. A palliative care progress note that had been entered two days earlier recorded the patient's wishes to be comfortable. A compassionate approach to the daughter allowed her to describe the panic that in fact she did experience and her deep grief in anticipation of losing her mother. With compassionate support from Peter, the daughter affirmed the previous commitment to comfort care for her mother. The patient died comfortably, in the presence of her family. Peter stated, "I would never have raised this question in the past. I would have gone along with the team, while holding these thoughts and moral distress to myself. CERN gave me the knowledge, communication skills and moral courage to speak in that moment, on behalf of the patient."

Diane, a nurse with thirty years of cardiac surgical ICU experience, shared how CERN spurred her to moral action

<table>
<tr><td colspan="6" align="center">**Table 2.**
Impact of CERN Program on Selected Measures</td></tr>
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	M (SD) Pre	M (SD)	Post	p	t
Moral distress	.82	72.04 (33.59)	56.82 (29.59)	< .0001	4.23
Knowledge	--	15.34 (1.75)	16.23 (1.92)	<.005	-2.86
Self-efficacy	.82	27.75 (5.87)	33.53 (5.42)	<.000	-8.7

Note: Paired samples t-test were used with a Bonferroni correction of alpha .05/3 = .017. Sample size = 67.

and had a positive impact on the care of a lung transplant patient who was nearing the end of life. Yet politics among the clinical teams created a barrier to providing the patient a transition to comfort measures. Diane explained,

> In CERN, I learned to describe the issues related to the case being considered in "ethical terms" rather than with emotion. As [an] ICU resource nurse, I was aware of my own emotion, that of the family, and the intense politics of the physician services involved. This awareness led me to choose my words carefully; in speaking of a benefit-burden analysis I was able to advance decision-making for the patient, without putting physicians on the defensive, and support the nurse caring for this patient as he worked effectively with multiple physicians, to make a pathway to a peaceful end of life for this patient.

Faculty Reflections

The transformative experience of the CERN project affected not only the participants but the faculty as well. We frequently remarked, as we listened to the narratives at the beginning but especially the end of each session, how moving and powerful was the effect of the multimodal teaching strategy on the course participants. One faculty member reflected, "The synergy of teaching modalities and the collective impact they had for the nurses was unexpectedly potent. In particular, the theoretical content on ethics combined with education on communication skills and then the role-play opportunities to practice putting together all these skills in a safe and supportive environment seemed to solidify learning and self-confidence for participants in a remarkable way." Similarly, another faculty member noted, "From participant reflections and narratives over the course of the CERN program I was continually astonished—as were the participants—by the depth and richness of their transformation into moral agents. Moreover, their agency diffused into their practice, setting enabling collaborations and empowering others."

A significant pedagogic element that we became more aware of over time was the power of the group. Spending ten months together (meeting monthly) created a unique environment for reflection, affirmation, and discovery for the participants and, by association, for us. The opportunity to learn and reflect in the deep way the residency provided to nurses, most of whom were midcareer, was unique and powerful. A faculty colleague pointed out that "many studies, along with the CERN participants' preprogram narratives, point to the fact that the majority of nurses still do not have the sort of preparation that allows them to be effective and compelling participants in team conversations about their patients." We witnessed course participants "find their voices" and acquire the understanding and confidence to speak up to colleagues on rounds or in team meetings about the ethical concerns they witnessed. We would all agree that it was a privilege to witness and assist with the process of learning, insight, and change that each of the CERN groups experienced.

Discussion

We believe that CERN is a pedagogical innovation that has had a positive impact on the attitudes, knowledge, and practice of nurses who participated in this residency, and, through their learning, has also demonstrated early evidence of a positive effect on patient care. Positive program evaluations, increased ethics knowledge, decreased moral distress, and more effective moral agency in practice provide objective measures of its usefulness to adult learners. Narratives shared by participants provide evidence of CERN's impact on their practice and the outcomes of patients.

The health care system is complex and traditionally characterized by professional hierarchies and prescribed role obligations. In this increasingly multilayered health care system, the professional nurse's role is the only role that has the privilege of twenty-four–seven contact with the patient's experience of disease and treatment, continuously assessing patients' and surrogates' responses, and intervening independently or collaboratively to provide what is needed to facilitate the patient's trajectory toward recovery, assisting him or her to tolerate uncertainty in prognosis, providing support in the journey toward end of life, and in some cases lowering costs. To this end, a sound health care system needs the voices of nurses—first-line professionals who can articulate emerging ethical problems in patient care and begin intervention to alleviate such problems. CERN has demonstrated initial evidence of effectiveness in achieving such goals.

Given our experience, we believe that CERN is replicable, and we would recommend a similar academic-clinical collaboration. We utilized the teaching and theoretical experience of our academic faculty member (Pamela Grace) in curriculum development and classroom methods. We utilized the clinical experience of two clinical ethicists (Martha Jurchak

and Ellen M. Robinson), who have extensive experience in ethics consultation regarding real-life ethical problems in the health care setting. We also sought the expertise of a professional skilled in communication strategy, namely, a hospital chaplain who has many years' experience in educating and mentoring chaplain interns and health professionals in a clinical pastoral education program (Angelika Zollfrank). Finally, a nurse researcher who could focus on evaluation of the program at large was essential to capture the impact of the program. Therefore, to replicate this program, we advise a team approach and seeking various forms of expertise as critical to its success.

The limitations of this program include the small number of participants from two hospitals; further testing is necessary to determine the extent to which CERN is replicable in other settings. The evaluation used one proven instrument, the MDS-R, and two author-developed instruments that have not yet been validated by psychometric testing using a larger population. In addition to the results gleaned from the MDS-R and these novel instruments, the narratives also provide evidence that the program achieved all four components of Rest's framework, leading us to believe that CERN may be useful to other health care professions. Interprofessional collaboration is essential to high quality and ethical patient care, and thus innovative educational models that support such collaboration are vital in today's challenging health care system. In addition, an organization's commitment to such a model inspires a work environment that supports ethical patient care. Future research should aim to document empirically the impact of ethics education on patient outcome.

Acknowledgment and Disclaimer

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