Letter to the Editor

RESPONSE

The authors of "Barriers to Innovation: Nurses' Risk Appraisal in Using a New Ethics Screening and Early Intervention Tool" are grateful to Celia Bridges, BA, BSN, RN, for her scholarly and eloquent analysis of our study on the feasibility of using an ethics screening tool to identify patient situations with an increased likelihood of ethical conflicts.[1] We certainly agree with Ms Bridges' major assertion that both system thinking and system change are required to enhance the moral landscape of practice settings. Agreement on that core idea leads us to question how to transform systems of care so that nurses and other providers along with patients and families can interact in meaningful and constructive ways when considering not only the science but also any ethical concerns. On the basis of our ethnographic research, we found that these conversations are often avoided and even when they do occur, nursing perspectives are sometimes not voiced or, when voiced, are frequently disregarded.[2,3] Even shared decision making, often viewed as the current standard in ethics, is a model designed to be between physicians and patients.[4] Our underlying assumption is that nurses have valuable insights into treatment benefits as well as burdens and therefore should be seen as a resource for patients, families, and other providers during these conversations.

However the question remains—how do we create systems that avoid "moral muteness"[5(p188)] in favor of promoting ethical mindfulness? Emanuel claimed that ethics is intricately woven into the "webs of interactions" that occur in the structure of care.[6(p151)] This seems to suggest that relationships are key to our moral commitments to patients and families. With that in mind, we need to consider how to build relational capacity and communication skills across disciplinary, cultural, sociopolitical, and moral difference. From our point of view, the foundational dynamic that underlies any relationship is the reflective and ethical mindfulness of individuals who are nested within interdependent ecosystems. The implication is that systems change when individuals inside those systems change just as much as individuals change when systems surrounding them change.

We acknowledge the important insights that Ms Bridges provides when stating, " . . . it may be more productive to conceptualize the escalation of ethical dilemmas as reflective of a faulty or dysfunctional system, rather than of a lack of agency on the part of individuals within the system." However, building on this idea, perhaps we need to replace "rather than" with the word "including" so that we acknowledge that systems transform not only from the bottom-up and the top-down but also from the many middles in all directions. This idea is described by Anderson[7] in a forthcoming anthology on emancipatory nursing as the tension between "individual agency" and "structural constraint." Anderson claims that seeing these as separate rather than related concepts often impedes nurses' work toward equitable relationships and social justice. Perhaps, when we as nurses begin to see ourselves as an important part of the systems that actually create the structural constraints, we might develop new insights on how to transform the systems in which we work and actually become "full partners with . . . other healthcare professionals in redesigning health care in the United States."[8(p4)] This notion will not "spare nurses from the requirement that they commit to actions perceived as personally or professionally risky." Rather, we will be thrown into the thick of change with all its uncertainties and murkiness—and yes, risk. However, it may become what Ms Bridges calls for—the "inversion of the status quo [that] change[s] the expectations of the individuals within the system"—all individuals within the system. But only if bold nurses move beyond "moral muteness" to create a chorus that challenges system constraints that give rise to the risk of speaking up. Only then will health care organizations transform from structural hierarchies to holarchies where entities (holons) are *simultaneously* viewed individually and as part of a system larger than itself.[9]

We believe Ms Bridges' ideas blended with our own provide helpful insights about ethical

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responsibilities—the most basic of which is for all system components to create systems with moral space where open, inclusive dialogue and constructive conversation on ethical aspects of care is expected and welcome. Many hold the keys to this change: nursing and physician leadership, ethics consultants, administrators—and perhaps even The Joint Commission needs to expand stipulations beyond simply requiring health care organizations to "provide an ethics process." Yet, ultimately, the individual, the one most directly involved, who witnesses the concern or the violation, is left with the responsibility to do something. This has been true all throughout history; it comes down to the one person giving voice. So, often it is the least powerful or most vulnerable who lifts his or her voice, often at great risk, and ultimately changes everything.

Respectfully,

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