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MORAL DELIBERATION BY NURSES AND MEMBERS OF THE ASSISTENTIAL ETHICS COMMITTEE IN A CLINIC OF MAGALLANES, CHILE

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ABSTRACT

Objective: to know how the nurses working in the Critical Care Unit for adults and the members of the Assistential Ethics Committee deliberate on the assistential ethical issues in a Clinic of Magallanes, Chile.
Method: a qualitative research of an exploratory and descriptive character conducted in a Clinic of Magallanes, Chile. Data collection was performed by means of a semi-structured interview in the period from March to May 2018, with ten nurses working in the Critical Care Unit for adults and with four members of the Assistential Ethics Committee who were clinical professionals in different disciplines. The statements obtained were organized in Atlas.ti and analyzed in the light of the theoretical reference framework of ethics, of principalist bioethics, and of Diego Gracia's moral deliberative method.
Results: the two professional teams that participated in the research showed having ethical values and principles: protection of human dignity; respect for the patients' rights in all scopes, contexts, and interventions, targeted to provide humanized clinical practices based on scientific evidence and in safeguarding the protection and fulfillment of the patients' rights.
Conclusion: nurses show knowledge, empathy, and moral sensitivity when conducting the moral deliberative model in assistential problems. The members of the Assistential Ethics Committee deliberate as a team and come to an agreed upon conclusion, always thinking in the best respect and benefit for the patient's well-being, with empathy and prudence in decision-making as references.

DESCRIPTORS: Ethics. Bioethics. Ethics Nursing. Moral deliberative method. Nursing care.

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DELIBERACIÓN MORAL POR ENFERMERAS (OS) E INTEGRANTES DEL COMITÉ DE ÉTICA ASISTENCIAL EN UNA CLÍNICA DE MAGALLANES, CHILE

RESUMEN

Objetivo: conocer cómo las enfermeras(os) de la unidad del paciente crítico adulto y los integrantes del comité de ética asistencial deliberan frente a los problemas éticos asistenciales en una Clínica de Magallanes, Chile.
Método: investigación cualitativa de carácter exploratoria y descriptiva realizada en una Clínica de Magallanes, en Chile. La recolección de datos fue realizada por medio de entrevista semiestructurada, en el período de marzo a mayo de 2018, con diez enfermeras (os) de la Unidad de Pacientes Críticos adultos y cuatro integrantes del Comité de Ética Asistencial que eran profesionales clínicos de diferentes disciplinas. Los discursos obtenidos fueron organizados en Atlas.ti y analizados a la luz del referencial teórico de la ética, bioética principialista y del método deliberativo moral de Diego Gracia.
Resultados: ambos equipos profesionales que participaron en la investigación demostraron poseer valores y principios éticos: protección a la dignidad humana; respeto a los derechos de los pacientes desde todos los ámbitos, contextos e intervenciones, dirigidos a entregar prácticas clínicas humanizadas, basadas en evidencia científica y en velar por la protección y cumplimiento de los derechos de los pacientes.
Conclusión: las enfermeras demuestran conocimiento, empatía y sensibilidad moral al desarrollar el método deliberativo moral en los problemas asistenciales. Los integrantes del Comité de Ética Asistencial deliberan en equipo y llegan a una conclusión en consenso, siempre pensando en el mayor respeto y beneficio para el bienestar del paciente, teniendo como referencias la empatía y la prudencia en la toma de decisión.

DESCRIPTORES: Ética. Bioética. Ética en enfermería. Método deliberativo moral. Cuidados en enfermería.

DELIBERAÇÃO MORAL POR ENFERMEIRAS (OS) E INTEGRANTES DO COMITÊ DE ÉTICA ASSISTENCIAL EM UMA CLÍNICA DE MAGALLANES, CHILE

RESUMO

Objetivo: conhecer como as enfermeiras(os) da Unidade de Pacientes Críticos para adultos e os membros do Comitê de Ética em Saúde deliberam sobre os problemas de saúde em uma Clínica situada em Magallanes, Chile.
Método: pesquisa qualitativa, exploratória e descritiva, realizada em uma clínica de Magallanes, Chile. A coleta de dados foi realizada por meio de entrevista semiestruturada, entre março e maio de 2018, com dez enfermeiras(os) da Unidade de Pacientes Críticos para adultos e quatro membros do Comitê de Ética em Saúde, sendo profissionais clínicos de diversas áreas. Os relatos coletados foram organizados em Atlas.ti e analisados considerando o referencial teórico da ética, da bioética principista e do método deliberativo moral de Diego Gracia.
Resultados: ambas as equipes profissionais que participaram da pesquisa demonstraram possuir valores e princípios éticos: proteção da dignidade humana; respeito pelos direitos dos pacientes de todas as áreas, em todos os contextos e intervenções, com o objetivo de assegurar práticas clínicas humanizadas, com base em evidências científicas e garantir a proteção e o cumprimento dos direitos dos pacientes.
Conclusão: as enfermeiras demonstram conhecimento, empatia e sensibilidade moral ao desenvolverem o método deliberativo moral nos problemas de saúde. Os membros do Comitê de Ética em Saúde deliberam em equipe e chegam a uma conclusão consensual, sempre pensando no maior respeito e benefício ao bem-estar do paciente, tendo como referência empatia e prudência na tomada de decisão.

DESCRITORES: Ética. Bioética. Ética em enfermagem. Método deliberativo moral. Cuidados de enfermagem.

INTRODUCTION

Scientific and technological advances revolutionized the history of Medicine and expanded people's life expectancy, enabling investments to sustain life, which often generates conflicts and ethical dilemmas for the health professionals. With the aim of supporting health-related decisions, renowned bioscientists tried to find out how these issues had been treated in the ethical committees of health institutions worldwide.[1]

The field of bioethics is diverse and is present in the health area, where, as a disciplinary body, nursing faces challenges which appeal to the scientific knowledge in ethics and bioethics, to the mastery of skills, and to use of tools that allow them to recognize the ethical issues in the care practice, as well as to make deliberated and prudent team decisions. These decisions make up ethical, humanized, and quality Nursing care, apart from patient care safety.

During the professional training in health, and especially in Nursing, education based on dialog, on the problematization of ideas, and on the development of moral competences in the students is necessary so that they are empathic themselves and have supporting pillars to make decisions based on ethics and to provide humanized care.[2]

When it develops its competences in quality care and patient safety in the Critical Care Unit (CCU) for adults, Nursing establishes an important interaction with the patient, who, due to closeness and dependence, creates a bond of trust with the nurses, ideally, when the patient's condition allows for it. The ethical duties of the health professionals in relation to promoting patient safety are shared with the health institutions as a whole.[3]

From a reflexive perspective, we notice that ethical conflicts are recurrent in the routine of the clinical practice. The implementation of the Assistential Ethics Committees (*Comités de* Ética *Asistenciales*, CEAs) aims at contributing to improve the quality of care provided to the patients with problems of an ethical nature in the care practice, providing guiding solutions to the patient and to the clinical team during hospital stay in the care practice.[4]

To recognize and face the ethical problems, the professionals need moral sensitivity, to consider their values and experience, and to use a code of professional ethics and other ethical references.[5]

There are methods which allow developing the reasoning and decision-making abilities in situations of uncertainty, skills that are used to solve complex problems.[6] Among them, the Moral Deliberative Method (MDM) proposed by Diego Gracia stands out. He is a Spanish philosopher, physician, clinical psychologist, psychiatrist, educator, and speaker on bioethics with world projection.[7] Moral deliberation is method of practical reasoning. It must be encouraged when the values and limits of human, individual, and collective life are at stake. Bioethics must collaborate in this task.[8]

The MDM has been successfully used for the last four decades in institutional, clinical-assistential, and research ethics committees, in the training experience of higher education in Health, thus opening a space for plural dialog and collective deliberation.[7] The MDM is proposed when there is a clinical situation with conflicts of values and when decision-making depends on the discussion of the possible courses of action by the health professionals. The courses of action are the possible ways out of a certain situation.[7]

The objective of the study is to know how the nurses working in the Critical Care Unit for adults and the members of the Assistential Ethics Committee deliberate on the assistential ethical issues in a Clinic of Magallanes, Chile.

METHOD

This research was conducted under the paradigm of the qualitative, descriptive, and exploratory methodology, with the aim of knowing the phenomenon under study, by using the participants' experiences expressed in their speeches and through the information gathered from various texts. From the specific experiences of the participants, it was considered as exploratory for being a health-related theme little studied in this region and in the specific context to the present day.

It was conducted in a health clinic of the Magallanes region, Chile. The human capital is composed of different professionals distributed in more than 80 generalist physicians from diverse specialties and supporting non-medical professionals who collectively add up to more than 372 individuals making up an interdisciplinary team composed of 54 nurses, midwives, psychologists, kinesiologists, nutritionists, speech therapists, medical technologists, higher-level paramedic technicians, a pharmaceutical chemist, managerial professionals, an engineer specialized in bioethics, IT specialists, business representatives, administrative clerks, and maintenance and support staff.

The clinic develops functions in the areas of medium- and high-complexity closed care, and it also provides open care made possible with 57 beds, with ten of them in the CCU for adults. The main function of the CCU for adults is caring for the users at life risk, who require permanent and continuous monitoring of their hemodynamics, with highly qualified staff and suitable competences to provide this care.

In the CCU for adults there are ten staff nurses, four nurses called for reinforcements and substitutions, support clinical staff called higher-level paramedic technicians, physicians working in 24-hours shifts, interconsulting physicians from different specialties, kinesiologists, nutritionists, and a secretary.

In 2012, Chile passed Law No.20,584 of Patients' Duties and Rights;[9] then the decree was published that initiated the creation of the Assistential Ethics Committees (CEAs) in all the health institutions of the country.[10] From that date until the present day, the CEAs have been institutionalized, and work is in progress to provide better conditions in terms of health care quality and safety for the patients which reflect in the changes oriented to the good practices in the different health areas in Chile. In 2010 a CEA is created in the clinic, initially made up by five professionals. Its structure was renewed in 2017 and, currently, it is made up by nine members who develop CEA functions in a periodic and protocolized way.

The research participants were divided into two study groups: ten professional nurses working in the CCU for adults, and four CEA members: two physicians, a psychologist, and a nurse.

Inclusion criteria: professionals with a permanent contract in the clinic and who have performed activities in the institutions for a minimum of twelve months prior to the interviews.

Different health disciplines were included among the CEA participants.

The aim of including the CEA members in this study, which also evaluated the nurses' knowledge on the ethical and moral support sustaining their professional practice, was to demonstrate the role of the Committee in supporting ethical decision-making in the ethical conflicts experienced by the health professionals in the care provided to the patients and their relatives.

The researcher arranged individualized meetings with each of the participants at different dates and times of their functions and according to their availability. In these meetings, general information about the research was provided and a data collection tool was socialized: the recorded semi-structured interview and the Informed Consent document. The participants were advised that they could decide on their participation, withdraw from the study if they wished so, and that they would not be in any way affected if they did not accept to participate. They were informed that confidentiality of their

identification would be safeguarded by means of codes that replaced their names, for example: Nurse 1 (E-1); Nurse 2 (E-2); Nurse 3 (E-3) (the letter "E" stands for "*Enfermero*" in Spanish), and so on.

The semi-structured interview was previously applied as a pilot in a sample made up of three professional nurses who did not participate in the study. The interviews were audio-recorded and transcribed into *Word*. A field diary and the Atlas.Ti software, version 7, were used for grouping and organizing the data collected for obtaining conceptual maps and linking networks, thus gathering the main ideas expressed in the participants' speeches that directed to the knowledge in the speeches found. In the interviews, the participants were asked about their knowledge on ethics, the principles of bioethics, and the MDM. Subsequently, a fictitious case was presented for the application of the MDM.

From the qualitative methodology, it was sought to know the facing strategy and how the nurses working in the CCU for adults and the participants from the CEA search for solutions and make decisions in the face of the ethical issues. Data collection by means of the semi-structured interview between the participants and the researcher is added the information obtained from the speeches in their historical context, which allowed discovering a local reality.

In the analysis of the data, the theoretical-methodological reference framework by Diego Gracia (Figure 1) was considered, as well as the concepts of ethics and bioethics.

The MDM is composed of eight sequential stages. It begins with the presentation of the clinical case that generated a conflict of ethical values and finishes with the most prudent decision-making for the situation, after validating the consistency tests. The most prudent decision is translated in order to select the best conduct for the context approached[8] (Figure 1).

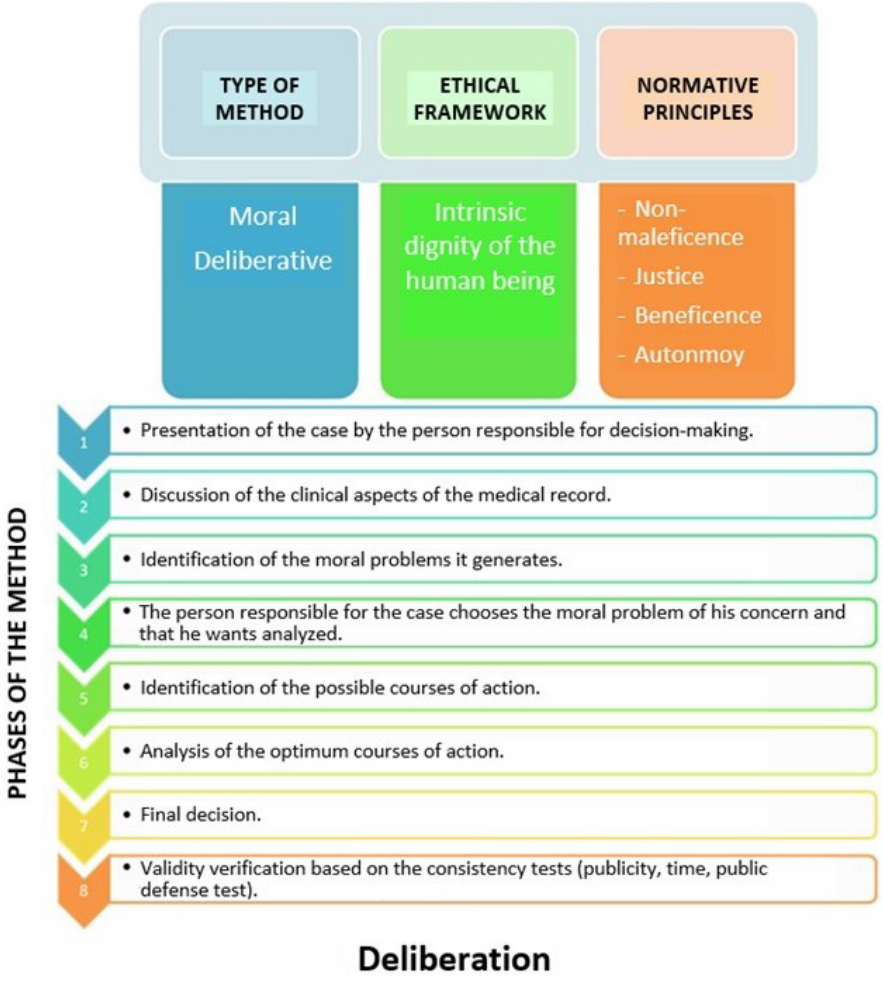

Figure 1 – Adapted from the Moral Deliberative Model.[8]

For the application of the moral deliberative model of the nurses and of the CEA members, the researchers prepared a fictitious case, though sustained by recurrent situations in the CCU care practice.

The research involves human beings, and complies with and observes the precepts of the Declaration of Helsinki (1964), amended in 1975, 1983, 1989, 1996, and 2001.

RESULTS

Initially, the profile of the study participants is presented and, subsequently, the nurses' knowledge on ethics, the bioethical principles, and the MDM applied to a fictitious situation. Then the CEA members apply the MDM to the same fictitious situation.

Profiles of the participating nurses working in the Critical Patient Unit for adults

A total of ten nurses working in the CCU for adults took part in this research. The age group included young adult women from 27 to 40 years old who had graduated between 2010 and 2016, with two to eight years working in the CCU, and five nurses acting as professionals for the last two years.

Profile of the Assistential Ethics Committee participants

Of the interviewed individuals working in the CEA in 2018, the four participants were health professionals (physicians, a psychologist, and a nurse), three were men and one was a woman, aged between 43 and 69 years old; three of them with 2 years in the CEA and 1 with 7 years; additionally, they had been active in the profession for 10 to 36 years.

Knowledge on the Moral Deliberative Method and how the Nurses proceed when facing situations related to clinical ethical issues

A fictitious usual case of an ethical issue was presented to all the nurses who participated in the study. A 20-day time frame was granted for its development, and the return of the response text occurred approximately ten days later.

From these responses a case was selected that represents the generality of the answers obtained, considering that all the nurses applied all the stages of the MDM. The answers were coincident in the course of prudent actions.

Referring the knowledge about ethics and about the MDM expressed in the speeches of the different nurses, the following are cited:

The moral deliberative method is a qualitative method of research in bioethics, it intends to perform an analysis with the objective of identifying the optimum solution to a conflict of values and, in this way, lead to reasonable decision-making. In the health area, life itself is one of the frequent conflicting values, and the other is the patients' or their representatives' decisions, scarcity of resources, beliefs, etc., many times in conflict with the users' values, and with those of the their families or legal representatives and of the care staff (E-5).

Analysis and development of the MDM. Aristotle mentioned that deliberation always precedes choices or decisions, or that its purpose is the action or decision that leads to the action, from what it is concluded that we deliberate to act by means of a process of reflection, of analysis of all the aspects of a complex situation, since it implies a conflict of opposing values which must be studied beforehand, in a unique context that cannot be generalized. For example, in the specific clinical case I cannot assume that the best course of action that is taken will be applicable to all the older adult patients with a diagnosis of advanced cancer. The idea is to generate a corpus of possible solutions and, by means of an in-depth analysis, come to an optimum and prudent solution (E-3).

The Moral Deliberative Model is a qualitative method of research in bioethics that intends to "*put an order*" *in the difficult decisions when they involve opposing values, in an attempt to preserve individual autonomy as much as possible without harming fundamental values. If systematically applied, it helps in the decision-making process for prudent decisions at the right time* (E-2).

Development of the Moral Deliberative Model ethical case by a nurse representing the Nursing team of the Critical Care Unit for adults

1. Presentation of the clinical case

Patient C.A.L., 98 years old, diagnosis: terminal cancer, stage IV, generalized bone metastasis, disoriented, dehydrated, querulous, with pain: EVA 9/10. Her daughter requests that all the support measures to sustain her mother's life are implemented.

2. Identification of the moral problems

Is the daughter's decision to exhaust support measures to sustain her mother's life to be respected?

Is it correct to impose an advanced life-support treatment when the patient is in a terminal condition?

3. Selection of the problem to be analyzed

The problem chosen is the following: Is it correct to impose an advanced life-support treatment when the patient is in a terminal condition?

4. Identification of the conflicting values

Autonomy: the value of the user's autonomy is being violated because she does not have the choice to make her own decisions regarding her life, the course of her disease, and the possibility of dying with dignity.

The value of life is in conflict when evaluating its very prolongation, despite her daughter's therapeutic obstinacy. That life can be sustained thanks to the advanced life support measures, with the eventual final outcome of the patient's death.

The decisions made by her daughter are respected, although the treating physician and the health team do not share them.

5. Bioethical principles

Beneficence: the daughter asks for advanced life support measures, although the treating physician believes that sustaining palliative measures should be taken.

Non-maleficence includes the principle of not causing harms. The health team offers palliative measures which are proportional to the management of the terminal stage of the mother's disease.

Justice: the daughter does not accept that and asks for advanced life support measures that will eventually cause harm to the mother and prevent her from dying with dignity.

Autonomy: the mother is not able to exercise this right and her daughter decides on her behalf.

6. Identification of courses of action

Extreme course of action

- The team giving way to the daughter's request, thus generating a therapeutic problem which will not allow for a dignified death of the patient.
- The clinic not providing care or palliative treatments to the patient.
- Intermediate courses of action
- The physician informs the responsible daughter on the terminal condition of her mother.
- Submitting the case to the ethics committee.
- Giving information to the daughter on the management of the dignified death of patients subjected to palliative care.
- Guaranteeing indications and care measures for the terminally ill patient and psychological support to the daughter.

Optimum course of action

- Decision-making by the treating physician and by the CCU medical team; all indicated home palliative care.
- Submitting the case to the bioethical committee of the assistential center and, subsequently, explaining the CEA guiding decision to the daughter.
- Respecting the patient's right to die with dignity, with palliative care, allowing her to die without pain and surrounded by her loved ones, is an assertive and clarifying decision for the daughter.

7. Final decision

The daughter eventually understands the significance of dying with dignity and with palliate care measures. Her mother will be cared for by professionals who will allow for an adequate management of pain, hydration, and comfort measures that will provide well-being to the user, apart from the company of her loved ones when she dies.

8. Consistency tests

The measures taken are totally legal and correspond to good praxis measures in the health teams in relation to dignified death.

Synthesis by one of the participants on the application of the Moral Deliberative Model by nurses working in the Critical Patient Unit for adults: presentation of the clinical case; discussion of the clinical aspects of the medical record; identification of the moral values and issues it generates; selection of the person responsible for the case, for the moral problem; identification of the conflicting moral values; autonomy; beneficence; non-maleficence; patient's quality of life; dying with dignity; professionalism; prudence; professional efficiency; and ethical responsibility.

Identification of courses of action: Extreme: Applying invasive measures. **Intermediate:** To continue providing palliative care to the hospitalized patient: administration of analgesics, oxygen therapy, hydration, monitoring, accompaniment by the family, humanized and close nursing care, psychological support for the daughter to cope with grief, etc. **Optimum**: Home palliative care: it implies the use of analgesics and hydration. **Final decision:** In my case, I choose the intermediate course of action as a prudent decision: hospitalization and palliative care; providing psychological support to the daughter so that she faces the denial process she experiments due to the impact of her mother's death, explaining to her that her mother will receive soothing palliative care and that she will not suffer during her hospitalization.

I discard the idea of home palliative care assuming that, as time progresses, the patient's condition is going to impair her general condition even more, that her daughter lacks the necessary knowledge to intervene, that she will be in distress, and she will again take her mother to a health care center for help.

Consistency tests: legality, publicity, and time.

Writing a guiding conclusion: *The nurses working in the CCU do not comply with this item. They know what a guiding conclusion means when the ethical issue is presented to the CEA. Then, deliberation and guidance take place, but not with a binding character* (EU-2).

Application of the Moral Deliberative Method by members of the Assistential Ethics Committee

The CEA members developed the MDM according to ethical and humanist philosophies, applying deontological codes of the role, privileging doing good to the patients, safeguarding the respect of their rights, understanding the principles of bioethics assumed with commitment and responsibility, using reflexive reasoning, and valuing the situation of belonging to the CEA.

They consider prudence, empathy, and work. Integrative and interdisciplinary teams are assembled as a fundamental factor for the CEA actions and functions. Such a factor is necessary to make deliberative and prudent decisions that respect others' opinions, and other opinions are accepted as better than one's own. Once the case decision is made, the consistency evidence is reviewed and, subsequently, the guiding decision is disclosed in writing to the person who presents the consultation. That decision has a consultive counseling nature and is not binding.

One of the participants developed the systematized and integral MDM by stages, based on bioethical principles, demonstrating understanding of the ethical issue, care experience, and knowledge of cases related to ethical issues, weighing the consequences of the decision made and making a prudent and ethical decision. He expresses that he understands deliberation in terms of conversations on equality and uncertainty conditions. He also assigns a moral value to the dignity intrinsic in human beings and respect for the patients' rights.

Analysis of the ethical, clinical and fictitious issue of the Assistential Ethics Committee. Moral Deliberative Method

An analysis is presented selected to represent the knowledge about the MDM by the CEA members. They had previously been handed in a document with the case of the ethical, clinical and fictitious issue recurrent in the clinical realities, similar to the one presented to the team of nurses. The answer was received in approximately ten days.

Level I - Facts

1. Presentation of the case, medical record, and clarification of doubts

Clinical aspects: report and description of the main diagnosis, current condition;

Assistential aspects: visits, service rules, etc.;

2. Patient's wishes

Patient with no autonomy, she did not express her will beforehand; the subrogate daughter demands the right for autonomy of the patient but does not have a power of attorney.

Legal aspects: The rights the patient has.

Level II - Values

3. Identification of problems and of conflicting values

a) Identification of problems and values: the autonomy principle in the terminally ill patient; her adult and emotionally unstable daughter asks for invasive treatments performed on her mother;

the patient's daughter puts pressure on the physician to take invasive treatment measures, which the professional considers disproportionate and expresses that the daughter demands futile care actions which are not based on evidence or on scientific knowledge. He also considers the palliative medical treatment as an adequate and suitable option for the patient's clinical condition.

b) Identification of principles: the physician applies the principles of beneficence, non-maleficence, and justice.

Level III - Duties

4. Proposing courses of action, deliberation

a) Extreme: performing invasive treatments as requested by the daughter.

b) Intermediate: applying home palliative treatments.

C) Optimum: performing palliate treatments on the hospitalized patient; allowing the disease to follow its natural course supported by analgesia, hydration, and clinical care actions.

5. Analysis

Utilitarian: the benefit assumed by the daughter is not real, and the cost/benefit ratio is not prudent according to medical-ethical knowledge.

Deontological: preserving life is the duty of the medical team.

In a broader sense, the theory of virtue or arethology constitutes one of the numerous answers to the questions formulated by the physician. Virtue comes from the Latin *virtus* and is synonymous with "*areté*" in Greek, meaning "the excellent quality of things or people to perform their functions". Moral philosophy deals with the virtues, their nature, development, and means to attain them. It also deals with the vices which oppose them and, under this conception, arethology is understood as a "catalog of virtues" belonging to a person.[11]

Arethological: the ethical issue is the following: Am I doing good? Am I doing evil? The physician formulates these questions and needs them to be deliberated by the CEA.

In this ethical issue, palliative treatment dignifies the patient's life.

The questions of "How do I have to act?" and "How do I have to prepare to act correctly?" constitute main ethical issues.

6. Courses of action

Deliberating the extreme, intermediate, and optimum courses of action weighs the patient's autonomy versus the ethical responsibility of the medical team.

7. Decision

I reassert that palliative treatment is the most appropriate and advisable medical choice.

8. Legality, publicity, and time tests

Legality: having the guidance of the legal representative in the debate.

Publicity: the guiding conclusion resists a publicity action.

Time: I would sustain the same prudent decision in time, as well as the principle of beneficence.

The decision is based on deontological and arethological concepts which dignify life and on the right to have an opportunity of dying with dignity. Finally, a guiding answer is prepared to the consultation submitted to the CEA in view of an ethical issue.

DISCUSSION

When assessing the application of the MDM by the nurses, it is observed that they apply it in various situations related to ethical issues with the necessary moral sensitivity to identify the ethical issues and to apply moral deliberation in the search for the most prudent decision for the patients and their families.

Moral sensitivity can be considered as an acute sense or a critical perspective that is used to recognize the moral problems, as a more acute o subtler permeability or reposefulness. The individuals can develop moral sensitivity or conditions to perceive the moral content of everyday actions, measures taken, and thoughts.[5]

When identifying situations related to ethical issues, the nurses' perceptions can be followed by feelings of moral concern or discomfort, which do not necessarily relate to negative or unpleasant effects on the theme. This is noticed through its productivity as conditions for reflection and moral deliberation, which allow visualizing moral problems that could otherwise stay hidden or unknown to the personal experience.[5]

In Nursing, discussion and reflection moments serve as a starting point in the construction of decisions, guaranteeing a prudent ethical decision. Ethical discussions do not exempt nurses from their responsibility to decide, and participation in the discussion will always be present in individuals who experience an ethical issue.[12]

In the ethical relationship between the health professionals and the patients and their relatives, the nurses working in the CCU for adults state that there is an ethical relationship in the care provided where multiple factors converge due to the criticality of the patients in this unit, who depend on autonomy and on their treatments. In the transition stage from life to death, the nurses provide humanized care with warmth and timely, keeping channels of open communication, extending family visits, respecting the patients' intimacy, and fostering respect for their spirituality according to their beliefs.[13] These conducts are assumed as a moral duty and adjust to comply with Law No.20,548, Chile**,** 2012.[9]

The CCU nurses demonstrate understanding and respect for the values of life, respect for the Law of Patients' Rights and Duties,[9–10] for the diversity of humanity, for the confidentiality of the patients' clinical data, for creeds and religions, and for the rights and duties of the individuals, as well as compassion for the people in sorrow, together with empathy, pity, humbleness, and reflexive and critical thinking. All these components represent moral values and a culture of Ethics, making up a corpus of knowledge that Nursing faces every day, and for which it is responsible as a discipline in the care practice.[14]

The realization of care as a final value of everyday Nursing lies in the integration of the ethical-moral and technical competences with co-responsibility and welcoming of the ethical demands involving the care actions.[15]

The researchers recognize the role of the nurses working in the CCU for adults; in their scientific and moral knowledge on bioethics, in the historical and cultural context, and in the condition that favors excellence in care for the patients, they visualize humanized care and contribute teachings to the interdisciplinary team that participates in the nursing team actions. These actions demonstrate the importance of the commitment to ethical and humanized care, and refer to the academic training and to the experiences of opposition with the moral values and ethical principles in situations that contribute to the rationale of the professional way of being that is based on ethical and moral values.[2]

In the application of the MDM by members of the CEA, it is observed that ethics is a fundamental contribution of bioethics. The participants state that there is a general bioethics which incorporates the tradition of the values and principles of the human beings' existence, and deals with the ethical fundamentals that signal common sense and decision-making. Thus, clinical bioethics deals with the

ethical conflicts and dilemmas that emerge in the routines of the health professionals, with the support of the principles used in general bioethics.[16]

They understand prudence as a virtue and as a reference for making ethical decisions; and prudence (from the Greek *phronesis*) is the key virtue for making ethically correct decisions. Additionally, it favors the estimation of what is best for the human being in what is attainable by actions and, for that reason, it has an imminent practical character. It is favorable that it is relevant, correct, and wise. Prudence is but practical wisdom, the perception of the will according to the correct desire which culminates in the right choice. Thus, by means of deliberation, the members of the CEA seek the most prudent decision.[17]

They use interdisciplinary dialog to solve the ethical issues of the care practice by means of the MDM, coming to a guiding conclusion in view of the queries received to be resolved and delivered to the person who submits them. This action coincides with what Abel[18] proposes: he states that only inter- and trans-disciplinary dialog, developed via deliberation, allows our plural society to find "the best way to solve ethical conflicts, respecting both patients' and health professionals' dignity."[18:75]

Collective deliberation expands the possible courses of action and helps the professionals who experience the ethical issue when they perceive they are not exempt from responsibilities, considering that ethical decisions are untransferable.[19] Collective deliberation configures itself as a constructing power of professional excellence oriented to the ethical debate applied to health themes.[20]

The CEA members recognize that the clinical professionals are instrumental in caring for the patients, they are empathy personified, the element favoring communication which consists in the ability to place oneself in the other's situation, and understand what they feel. This is fundamental to understand the other's feelings and emotions.[21]

Deliberation enables the perspectives that contribute to changing previously conceived ideas. Deliberation is conducted on what is opinionable, i.e., that which has some reasons for but also other reasons against. It is impossible to achieve total certainty. Prudent reasoning always admits more than one solution. The very same fact can be object of two or more decisions, all prudent, and which can be different and opposing. This is inherent both to the clinical and to the ethical scopes.[4]

In the discussion about similitudes and differences of the nurses' knowledge and that of the CEA members on the MDM, it can be perceived that, in the development of the case, the nurses can recognize the very own skills and values of Nursing. They demonstrate mastery of the MDM, some to a greater depth than others, and agree that it is the most appropriate way to approach the complexity of the cases related to assistential ethics issues. They have sound theoretical training from the works by Diego Gracia, they cite bibliographic definitions, assert that this method is pertinent to define and make decisions in the view of conflicting values and different views among the health professionals, the patients and their relatives (there can even be disagreements among the health professionals themselves). They assert the protocolized steps of the MDM and their importance when facing clinical-ethical conflicts.[22]

In order to adopt the MDM, the professionals need to have personal predisposition, which includes ability to listen, recognition of deficits, and listening to the others' argumentative reasons.[23] From the appropriation of scientific knowledge and from the internalization of the moral values to support the professional practice, investment in moral construction during training can contribute to supportive and humanized Nursing.[2,24]

The participating CEA members deliberate from the scientific knowledge stemming from their academic training and from the assumption of deontological codes; reflexively and prudently, they apply critical reasoning, validate the principles of bioethics, weigh the consequences of the decisions made, value the respect for life, quality of life, and the intrinsic dignity of the human being. They develop the analysis of the ethical issues by using the principles of the principalist bioethics to deliberate as an

interdisciplinary team, with the MDM as a reference to seek the common sense necessary to make reflexive and prudent decisions in virtue of favoring patients' dignity and quality of life and the respect for their rights, from all the scopes of health care.[25–26]

Eventually, deliberation is not a natural behavior but a moral one. To deliberate is a self-education process. The practical reason is deliberative, but deliberation is a difficult task. It needs many possibilities like the absence of external restrictions, good will, ability to offer reasons, respect for the others when they disagree, and the desire of understanding, cooperation and collaboration. Deliberation does not lean on decision but on commitment.[8] This commitment was translated by the words and actions of the participants in this research when applying the MDM and in the demonstrations of moral sensitivity during their everyday practice.

CONCLUSION

The nurses working in the CCU for adults that participated in this study show understanding and respect for the patients, according to the Chilean Law of the Patients' Rights and Duties, created in 2012, which establishes respect for the values of life, for the intrinsic dignity of the human being, and for the moral integrity and values of each person. From their speeches, the value they attribute to ontology is highlighted, assigning value to the concept that "every human being is a person", and that knowledge on ethics and bioethics is present both in values and in empathy, pity, compassion, humbleness, and reflexive and critical reasoning. They perform their disciplinary role accompanied by moral values that help the patients and their relatives, who need the art of their discipline.

They demonstrate commitment and responsibility, and establish close, empathetic and humanized communications in their dealings with the patients and/or with the subrogating relatives when the patients have lost their intellectual ability. They represent a good contribution to the knowledge on ethics and bioethics for the management of the ethical issues of the care practice, assembling collaborative teams, leaning on the procedures, treatments and therapies, as well as on the solutions to the patients' ethical issues.

In their speeches, the CEA members who participated in this research state their knowledge on moral and disciplinary development, respect the principles of the principalist bioethics and the moral values when deliberating for decision-making. They apply the MDM, assert that they are able to deliberate in team and to come to an agreed upon conclusion, always thinking in the greatest respect and benefit for the patients' well-being; they understand ethics and bioethics as a moral commitment which is necessary for the patients' rights and well-being; and they assert that they apply the art of prudent and reasonable deliberation in conditions of equality.

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NOTES

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