

HOW DO RESPIRATORY CARE PRACTITIONERS
LEARN TO MAKE DECISIONS ABOUT ETHICAL DILEMMAS

by

CHARLES ROBERT MATSON

(Under the Direction of Bradley Courtenay)

ABSTRACT

One key aspect to the responsibilities of a Respiratory Care Practitioner (RCP) is to make decisions in ethical dilemmas. RCPs are often placed in situations where ethical dilemmas will arise and morals will be challenged. The purpose of this study is to understand how Respiratory Care Practitioners (RCPs) learn to make decisions when presented with ethical dilemmas in their practice. The study was guided by the following research questions: (1) under what circumstances do RCPs engage in decisions involving ethical dilemmas, (2) what is the learning process for RCPs who engage in ethical decision making, and (3) how do contextual factors influence decision making in ethical dilemmas for RCPs?

This qualitative study used interviews to explore ways RCPs learned to make decisions in ethical dilemmas. A purposeful sample was used to determine the fifteen RCPs with at least three years of experience. Criteria were used to reflect the diversity of in the field of Respiratory Care. The categories that emerged from the data included (1) the ethical dilemmas faced by RCPs and where they occurred, (2) the steps and influences in ethical decision making, and (3) the learning processes of the RCP in making decisions in ethical dilemmas. Three conclusions were made from data. The first conclusion suggests that RCPs view life and death situations as a prominent

ethical dilemma in their practice. The second conclusion found that RCPs did identify a process for making decisions in ethical dilemmas that had commonalities with the literature. The last conclusion suggested that RCPs learn to make decisions in ethical dilemmas from aspects of informal learning such as colleagues and the RCPs' experiences in the clinical environment. Implications for practice included structured educational endeavors to strengthen the RCPs ethical decision making process. Recommendations for future research included the extent formal learning played a part in the RCPs decision making process, the extent hospital administrators view the importance of ethics in the healthcare environment, ethical decisions made in places with excellent reputations, the other ethical dilemmas RCPs face in their practice, and the decision making process in ethical dilemmas of RCPs with less than three years' experience.

INDEX WORDS: Respiratory Care Practitioner, Informal Learning, Ethical Dilemma,
Continuing Professional Education, Adult Education

HOW DO RESPIRATORY CARE PRACTITIONERS
LEARN TO MAKE DECISIONS ABOUT ETHICAL DILEMMAS

by

CHARLES ROBERT MATSON

B.S., Medical College of Georgia, 1980

M.Ed., University of Georgia, 1998

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial

Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2012

© 2012

Charles Robert Matson

All Rights Reserved

HOW DO RESPIRATORY CARE PRACTITIONERS
LEARN TO MAKE DECISIONS ABOUT ETHICAL DILEMMAS

by

CHARLES ROBERT MATSON

Major Professor: Bradley C. Courtenay

Committee: Ronald Cervero
Roger Hill
Thomas Valentine

Electronic Version Approved:

Maureen Grasso
Dean of the Graduate School
The University of Georgia
May 2012

DEDICATION

This research is dedicated to Karen, my wife and my children, Janna and Sam who understood the times I could not participate in events as I was working on my doctoral study. I hope that my children will recognize the importance of learning, hold it precious, and share it with the people they come into contact. I also want to dedicate this research to three people that saw me begin the process, but are not here now to see me finish, my mother, my father, and my best friend.

ACKNOWLEDGEMENTS

I would like to thank Dr. Courtenay for your patience, guidance, and understanding. You have shown me the way to interact with learners and guide them. You are truly a teacher, someone that not only teaches about a specific subject, but one who teaches about life. I am eternally grateful that I had you as a teacher and a mentor. Words will never be able to express my appreciation of our time together.

I also wish to express my gratitude to my other committee members:

Dr. Cervero, thank you for allowing me to openly share my thoughts in your classes and during this dissertation process. I have learned the nature of power as it pertains to relationships and the responsibilities that go along with it. You have taught me to be open-minded and share my knowledge with others.

Dr. Hill, thank you for opening my eyes to Rushworth Kidder's work in ethics. I have learned a great deal from you in the times we met. You patiently allowed me to espouse my views on ethics, and gave me much to ponder.

Dr. Valentine, thank you for sharing with me the passion you have for adult learning. I have learned a great deal from you relating to research development and theory. I will always treasure your insight into qualitative research that you revealed to me in my comprehensive review.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	v
LIST OF TABLES	ix
CHAPTER	
1 INTRODUCTION	1
Ethical Decision Making.....	3
Respiratory Care Practitioners (RCPs) and the Dilemmas They Face	5
Opportunities for Learning to Make Decisions in Ethical Dilemmas.....	6
Problem Statement	10
Purpose Statement.....	12
Significance of Study	12
2 REVIEW OF THE LITERATURE	14
Introduction.....	14
Ethics.....	14
Ethical Dilemmas.....	16
Ethical Decision Making in Selected Professions	19
Ethics and Adult Education	21
Ethical Decision Making Processes	25
Ethics in Respiratory Care	29
Continuing Professional Education.....	30
Summary	38

3	METHODOLOGY	39
	Design of the Study.....	39
	Sample Selection.....	42
	Data Collection	45
	Data Analysis	48
	Validity and Reliability.....	49
	Research Bias and Assumptions	52
	Summary	53
4	FINDINGS	55
	Introduction.....	55
	Participants.....	57
	Results.....	70
	Summary	99
5	SUMMARY, CONCLUSIONS, DISCUSSIONS, IMPLICATIONS, AND RECOMMENDATIONS	101
	Summary	101
	Conclusions and Discussion	102
	Implications for Practice	112
	Recommendations for Future Research	116
	REFERENCES	119
	APPENDICES	
	A AMERICAN ASSOCIATION FOR RESPIRATORY CARE POSITION STATEMENT.....	130

B	HOW DO RESPIRATORY CARE PRACTITIONERS LEARN TO MAKE	
	DECISIONS ABOUT ETHICAL DILEMMAS INTERVIEW GUIDE.....	132

LIST OF TABLES

	Page
Table 1: Participants Demographics	57
Table 2: Learning to Make Ethical Decisions in Respiratory Care	70

CHAPTER 1

INTRODUCTION

Respiratory Care Professionals (RCPs) are taught to make decisions on ways to diagnose and treat patients. Skills are taught in a formal classroom and laboratory setting and reinforced in the clinical environment. At any given time, quick decisions must be made in order to prevent a patient's deterioration. RCPs must think quickly and clearly to deliver the best care to their patients.

Upon graduation, employers reinforce the techniques and decision making skills learned in a formal classroom environment. In my brief career, I have been taught by professional educators ways to care for my patients. There are times when it takes all that I learned in the formal classroom setting and in the clinical environment to make quick decisions in a crisis. A true experience may help clarify this position.

My patient is a twenty – seven year old male that fell off a ladder and sustained a head injury. He has a wife and two young children. A machine is breathing for him. After a few days of treatment, the physicians have determined that this young man has no brain function. My patient is an organ donor. The procurement team has assembled this day to take my patient's organs. My job is to transport the patient to surgery and ensure that he is oxygenating. I make sure that the breathing machine is functioning correctly during the procurement and terminate the machine at a predetermined time.

We arrive in the operating room. It is cold and dreary. I monitor the patient's breathing and oxygen level. All is well with the breathing machine and the patient's oxygen level. The

surgeons and nurses arrive and begin the procedure. My eyes roam around the room. I watch as the surgeons operate on the patient. Out of the corner of my eye, one of the indicators on the breathing machine lights up. This light means that the patient is breathing spontaneously, without the help of the breathing machine. It cannot be; he is incapable. What is going on?

I quickly evaluate the breathing machine and everything is functioning correctly. I must have been seeing things. That light indicates that the patient was taking a spontaneous breath and he cannot, he is brain dead. No, it must have been me imagining something. I turn to the surgeons, and they have opened the chest and meticulously palpate the organs they are to remove. I turn back to the machine and the indicator lights up again. I saw it plainly this time. Is the patient making an attempt to breathe?

I go back over all of the settings very closely. The patient is receiving ten breaths per minute from the machine, but the breathing machine indicates that a total of thirteen breaths are given. This cannot be. That would mean that the patient is breathing independently, and he is not brain dead. The surgeons are deep into the operation. What do I do? My options are to inform the physicians of my observations or to ignore them. I rationalize that the neurosurgeons would not have pronounced this patient brain dead, if it were not true. There is no chance of recovery. This is a fluke. In a very few minutes the surgeon will cut the aorta, and we will be at a point of no return. I really hate my job right now. I am at an ethical crossroad. I need to make a decision, and I need to make it fast. In school I was taught many things, even a code of ethics for RCPs (see Appendix A). It is not clear how this code of ethics for Respiratory Care Practitioners relates to the in-depth, day to day bedside decisions. Like most codes of ethics, the code of ethics for RCPs is vague and really did not mean much until now.

Codes of ethics are vague and it may be difficult for a RCP to transfer the words in the code of ethics to a specific situation where an ethical decision is required. Gordon and Sork (2001) recognize the inadequacies of a code of ethics as they write,

the decontextualized nature of codes and their consequent irrelevance to many problems of practice, the privileging of elites who usually hold positions of power that enable them to develop and enforce codes, and the impossibility of developing a meaning code that is broadly acceptable, relevant, and enforceable given the diversity of the field. (p. 203)

Gordon and Sork are referring to adult education, but the same can be said for the RCP's Code of Ethics. The RCPs code of ethics is vague and is difficult to apply in routine situations that RCPs encounter.

Ethical Decision Making

Not all decisions like the one described in the previous section have an ethical basis, and surely there will not be ethical dilemmas for every decision. Shea (1978) writes that many of the necessary decisions involve making choices among mutually exclusive ends and means which are based upon a value position. Sork (1988) states, "The pressure to get the job done, to conform to the institutional policies and practices, to accept established norms, and to respond to the needs of the clients, all make it difficult to question the moral basis for decisions made and action taken" (p. 34).

Making ethical choices can be a haphazard event, or a well-planned process. Brockett (1988) described the decision making process as one in which the decision maker can be unreflective with the decision based upon hunch, tradition, organizational hype or other factors, or one that is based upon a consistent, defensible, philosophical position. When the choice is not

in conflict with other competing courses of actions, then the choice may be easy to accept. It is when the choice competes with other choices of value that an ethical dilemma ensues. Shea (1978) describes a dilemma as a choice that has no acceptable resolution. In other words, some negative consequences can be seen as the result of the decision. Merriam and Caffarella (1999) write, "Ethical dilemmas are dilemmas because of this complexity in thinking about what constitutes right and wrong. There are no simple answers" (p. 287). An ethical dilemma forces a person to choose between courses of action with competing or conflicting values.

Many authors believe that the decision about an ethical dilemma should involve a well thought out process (Brockett, 1988; Carroll, 1996; Edge & Groves, 1994; Laszniak, 1983; Merriam & Caffarella, 1999; Shea, 1974; Sork, 1988; Starratt, 1994). Even if the decision makers do nothing, then they may be asked to justify their non - decision. Brockett's (1988) approach was not as detailed, but he did emphasize reflecting on the process. He writes, "As practitioners reflect on the ethical content of their choices, they will encounter dilemmas that should be resolved" (p. 37). As suggested by Shea (1978) reasons, "without means of validation, one's actions are only actions. Their interpretation becomes statements of principles or standards only when a means of validation exists for them" (p. 122).

Ethical decisions are based upon our philosophy of life or our "value system." In order to determine our "value system," we must introspectively reflect on what is important to us. Those things that are important must be imbedded in a standard or principle. Shea (1978) describes this principle as a statement of truth which issues from scientific facts or philosophical concepts and theories which serves as a guide for actions or decisions concerning the education and or welfare (right or good) of persons.

Respiratory Care Practitioners (RCPs) and the Dilemmas They Face

Many dilemmas exist in medical practice where RCPs must make ethical decisions. One area where a RCP may need to make an ethical decision in a specific situation is when life support is terminated. When a patient is deemed to be in a persistent vegetative state, life support may be ordered to be discontinued. It is the responsibility of the RCP to discontinue mechanical ventilation knowing that it is likely the patient will die. The sanctity of life issue conflicts with the quality of life issue. The RCP will need to make a decision as to whether to follow the physician's order or relinquish the responsibility to someone else.

In a less dramatic fashion, a RCP may have limited equipment resources regarding patient monitoring. When two or more patients need the same piece of equipment, the RCP must make the decision as to which patient will receive it. The decision as to who will receive the equipment may be determined on a first come, first serve basis. The decision could also be decided by the patient's condition, age, prognosis, or the likelihood for survival. Likewise, when the number of patients treated exceeds the numbers of practitioners available, triage takes place. Triage allows practitioners to decide which patients receive care and which ones do not. One of the standards of the RCPs code of ethics is to treat each patient equally.

A RCP may be an acquaintance of the patient in treatment. If upon reviewing the patients chart, the RCP reads that the patient has a communicable disease, the RCP can tell no one outside the medical community this information. If the patient is romantically involved with a friend of the RCP, and the friend does not know of the communicable disease, the RCP is obligated not to divulge this information. If the RCP does communicate with the friend the information written in the chart, the principle of confidentiality has been breached.

A RCP may be tempted to falsify documentation to the benefit of the patient. Medicare and Medicaid guidelines are very strict for payment of supplemental oxygen. In the hospital, the patient may need oxygen and feels better when it is being used. If the patient does not meet the strict guidelines set forth by Medicaid and Medicare, the patient will not be able to go home on oxygen. The RCP may be tempted to falsify the patients chart in order for the patient to receive the oxygen. This action goes against the principle of veracity.

In the everyday routine of RCPs, medical dilemmas arise frequently where ethical decisions need to be made. The RCPs two to four years of formal education may touch on medical ethics, but more than likely they receive only information on the code of ethics for RCPs and not the specifics of making decisions in ethical dilemmas. During the RCPS thirty to forty years on the job, how are the identification of ethical dilemmas learned and how do RCPs learn how to respond when faced with a decision that involves medical ethics?

Opportunities for Learning to Make Decisions in Ethical Dilemmas

Formal professional education can provide for theory, and theory works well in practice if everything falls into place. Formal professional theory works when the situation is well defined. In their formal education RCPs learn how to administer medications, perform lifesaving therapy, and intervene before patients digress to respiratory failure. Diagnostic and therapeutic procedures are learned. Curriculums are developed to enable RCPs to fulfill these duties and critically think through problematic situations. Within the RCPs professional education, two organizations exist that determine the educational direction of Respiratory Care. The Committee on Accreditation of Respiratory Care (CoARC) outlines the curriculum necessary for Respiratory Care. Within the curriculum CoARC mandates that medical ethics is taught. CoARC, however, does not dictate how much medical ethics is required, nor does CoARC define what the learner

must learn. CoARC leaves what is to be taught to the individual Respiratory Therapy programs and the National Board of Respiratory Care (NBRC). The NBRC is the national organization that evaluates all RCPs. The NBRC's testing matrix is extensive including most aspects of respiratory care. The exam items are based upon job analysis surveys across the nation. The exams are very thorough when it comes to evaluating therapies, assessments, diagnostics, and implementing treatment, but nowhere in the matrix or the exam is ethical decision making evaluated.

When Respiratory Therapy students graduate and accept a position in an organization, an orientation is provided. This orientation includes a review of institutional policies and procedures, a competency check, and working with a mentor. Orientations may last a few weeks to a few months depending on the type of institution and the position that the RCP accepts. While working with the mentor, the novice RCP concentrates mostly on performing procedures accurately and time management issues. Benner (1984) acknowledges that the novice is limited in the responses for specific situations. To a novice everything is important when it comes to patient care. Their discrimination skills are poor. The novice is too interested in getting the "things" done for the patient and does not realize when something is going wrong. When they realize something is wrong with the patient, it is usually late in the situation. The mentor will keep the novice on task and on track.

We assume that all learning is positive, but as Dodge points out, learning can produce ill effects. If educators can better understand the ways professionals learn, then learners can be directed and guided so positive outcomes can be realized. Schön (1987) describes the balance between technical knowledge and artistry in professional learning. He gives examples in professions such as coaching, architecture, and music. Schön understands that technical knowledge is not enough for the professional to perform his/her work. Situations will arise that

do not follow what is written in books. Schön writes, “In the swampy lowland, messy, confusing problems defy technical solution” (p. 3). In twenty years of practice, I have come to realize that medicine is more about art than science. Even though science is the basis for much of the diagnostics and treatments in medicine, a good practitioner will rely on intuition and feelings in difficult situations. Even though we in medicine depend greatly on science, when things get “messy” it is usually the art that pulls the patients’ through the ordeal.

Houle (1980) writes, “Professional education is that which prepares one to practice a profession” (p. 87). Professional education consists of preservice education and continuing professional education. In preservice education, RCPs learn from competence models of education. According to Mott (2000), “The goal of the competence model is to build curricula based on competencies required in specific work settings and enhanced through relevant exercises, role playing, case studies, and problem solving” (p. 23). Cervero (2000) acknowledges that this preservice professional education takes a relatively short period of time to make practitioners competent in their daily duties. Continuing professional education should take place routinely over the professional life of the practitioner. Cervero (2000) points out

Until recently, however, little systematic thought was given to what happens for the following forty years of professional practice. Many leaders in the professions believed that these years of preservice education, along with some refreshers, were sufficient for a lifetime of work. (p. 4)

So why do educators place so much energy and money on educational endeavors? Dodge (1998) writes,

that a large body of “unintentional” learning exists within the workplace which is not the result of conscious decisions and lacks critical reflection on the possible outcomes. These

learnings may have negative consequences that are at odds with stated or intended policy.

It suggests actions which can be taken to identify and mitigate unintentional learning and their outcomes. (p. 109)

Houle (1980) asserts that, “the goal of all continuing professional education is the improvement of the ongoing performance of practitioners” (p. 91). This goal is achieved by educational endeavors such as in-service education, formal seminars, journal clubs, and on the job learning. For twenty years I provided RCPs with these types of educational endeavors in an acute care facility environment. However, the effectiveness of these types of educational endeavors is questionable. As Cervero (2000) observes,

This picture is universally recognizable to people in any profession as it is criticized for being largely ineffective in improving performance of these same professionals. Indeed, the familiarity would be funny if the importance of continuing education were not so great. (p. 3)

In-service education is an effort to keep professionals abreast of the newest theory, skills, techniques, and equipment. Practitioners gather regularly, and a lecturer presents information that is supposed to improve the professionals practice. Cervero (2000) characterizes these educational endeavors as “devoted mainly to updating practitioners about the newest developments, which are transmitted in a didactic fashion and offered by a pluralistic group of providers that do not work together in any coordinated fashion” (p. 4).

As with most professions, RCPs must maintain a specific number of continuing educational units (CEUs) in order to maintain a license. These CEU offerings also occur regularly, but not quite at the pace of the in-service training. Even though the intent of CEUs is to present useful information to every practitioner, the intent falls short. Daley (2000) states,

“We know that most CPE programs are more effective in teaching novices than in fostering professional development of experts” (p. 33).

A multitude of educational endeavors have been provided to practitioners in the hope of having positive learning experiences for the entire professional staff. For example, the journal club is designed to provide the experts with an opportunity to read about the newest theory and technology and interpret it for the novice. The professional expert investigates a new technology from peer reviewed journals and in a small group explains the results to those who do not have the expertise to put the theory into practice. Exchanging of ideas occurs with critiques of the premise and research techniques.

The problem with all of the aforementioned educational endeavors is that they do not place much information in the context of the workplace about ethical decision making. It does not meet the place that Schon (1987) describes as the “swampy lowland, messy, confusing problems” confronting practitioners. Daley (2000) describes on the job learning where “professionals construct a knowledge of their practice by linking concepts form new knowledge with their practice experiences” (p. 35). In formal school, the RCP is provided with very little information regarding ethics and even less regarding making decisions in ethical dilemmas. In the work place, ethical decision making is not even addressed although ethical decision making occurs routinely.

Problem Statement

Respiratory Care Practitioners are involved in complex decisions regarding patient diagnostics and treatment. On a routine basis dilemmas arise where the RCP is expected to make ethical decisions. These medical, ethical decisions have impact on patient care, patient relations,

and public trust. The decisions need to be identified, well thought out and acted upon. It is imperative that RCPs make good decisions when presented with ethical dilemmas.

A general code of ethics exists for Respiratory Care Professionals and ethics may be taught in the formal classroom environment. However, the subject matter that is taught is not included on the NBRC's exams. From the institutions' respiratory therapy curriculum to the absence of exam questions on national exams, it is of little wonder that medical, ethical decision making receives very little if any attention in the RCP's formal education.

Most states mandate licensure for RCPs and CEUs must be earned on an annual basis. CEU offerings occur regularly, but not quite at the pace of the in-service training. Even though the intent of CEUs is to present useful information to every practitioner, the intent falls short. Even when CPE programs are conducted, very little time is devoted to ethical dilemmas and decision making. For example, in 2007 and 2008, 108 continuing education hours were offered for RCPs by Georgia, Alabama, Tennessee, South Carolina, and Florida, states that have licensure. Not one of these 108 hours was dedicated to ethics. The American Association of Respiratory Care (AARC) offers continuing education hours that can be earned on line and in web casts. From July 17, 2003 until January 8, 2008, 112 continuing education hours have been provided. Not one of these hours is dedicated to ethical issues involving practitioners making medical, ethical decisions.

RCPs are making decisions in situations where ethical dilemmas are evident. How these ethical decisions happen is not documented. These decisions may be good decisions, but they could also be poor decisions. Regardless of the decision, the RCP will learn from that situation. We need to study how expert RCPs learn to make these decisions in order for adult educators to

plan curriculum and continuing education to better prepare the practitioner to make ethical decisions in ethical dilemmas.

Purpose Statement

The purpose of this study is to understand how Respiratory Care Practitioners (RCPs) learn to make decisions about ethical dilemmas in their practice. The study will be guided by the following research questions:

1. Under what circumstances do RCPs engage in decisions involving ethical dilemmas?
2. What is the learning process for RCPs who engage in ethical decision making?
3. How do contextual factors influence making decisions in ethical dilemmas for RCPs?

Significance of Study

This study has practical and theoretical significance for adult education from several standpoints. From a theoretical viewpoint, this study expounded upon the learning process of making decisions in the context of ethical dilemmas. Even though much is written regarding ethical issues in medicine, no studies have been identified as to how RCPs learn to make decisions over ethical issues. It also built upon the work of Brockett (1988) and Starratt (1994) in the area of ethical decision-making. Both Brockett (1988) and Starratt (1994) describe why people make the ethical decisions that they do. Both assume that people have learned how to make decisions. No empirical research has been identified as to how people learn to make decisions.

The findings of this study will be useful to adult educators who facilitate courses in medical ethics. Once the process of decision making in ethical issues is identified, then more effective ways to facilitate learning can occur. Educators will be able to facilitate ethic courses that will produce the greatest learning. Since decision making is an important aspect of the

RCP's practice, it is necessary for learners to refine this process. Employers will be able to reinforce this educational endeavor to provide an environment that will enable the learner to improve the decision-making process. The learner will be able to enhance his/her lifelong learning skills, developing sound decision making process when presented with ethical issues.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

The purpose of this study is to understand how Respiratory Care Practitioners (RCPs) learn to make decisions about ethical dilemmas in their practice. The study was guided by the following research questions:

1. Under what circumstances do RCPs engage in decisions involving ethical dilemmas?
2. What is the learning process for RCPs who engage ethical decision making?
3. How do contextual factors influence decision making in ethical dilemmas for RCPs?

To prepare for this research, I reviewed the literature pertaining to ethics, decision making, ethical decision making, learning, medical ethics, and continuing professional education (CPE). Searches in the these areas included the following databases: Macon State College Galileo catalogue, UGA Galileo catalogue, Health Source: Nursing / Academic Edition, Medline (at EBSCO host), CINHL (full text), ProQuest Nursing and Allied Health Source, the Professional Development Collection, ERIC (education) at EBSCO host, Research Library (at ProQuest) Dissertation Abstracts and electronic journals and text.

Ethics

Ethics is a vast and rich branch of philosophy. Plato and Socrates brought to the forefront the notion of ethics as a philosophical entity. According to Frankea and Granrose (1974), Socrates was "the man to start moral philosophy in the West and was himself its noblest

embodiment" (p. 2). Even though the West's ethical foundation can be traced to the Greeks, the way we define ethics varies.

Being a branch of philosophy, ethics can be viewed as a vast subject. Pozgar (2013) is more specific when describing this branch of philosophy when he writes,

Ethics is the branch of philosophy that seeks to understand the nature, purposes, justification, and founding principles of moral rules and the systems they comprise. Ethics deals with values relating to human conduct. It focuses on the rightness and wrongness of actions, as well as the goodness and badness of motives and ends. Ethics encompasses the decision making process of determining ultimate actions-what should I do, and is it the right thing to do. (p. 2)

Ethics do encompass a wide array of areas, but the main focus is on the decisions made based on values and accepted boundaries.

Dewey and Tuft (1932) write, "The term ethics and ethical are derived from a Greek word 'ethos' which originally meant customs, usages, especially those belonging to some group as distinguished from another, and later came to mean disposition, character" (p. 2). Dewey writes (1932), "They are thus like the Latin word 'moral' or the German *sittlich*, from *Sitten*" (p. 2). Like Dewey and Tufts, many authors interchange the terms morals and ethics (Carrol, 1996; Davis, 1997; Jarvis, 1988). Singarella and Sork (1983) define ethics from the philosophy of education viewpoint. They refer to axiology. Axiology relates to theories of value and ethics. Brauner and Burns (1965) further define axiology as "an analysis of moral beliefs, judgments, and concepts in the creation and discovery of a theory of value" (p. 9).

Ethics are concerned with good and bad, right and wrong, along with what we should (ought to) do for others. Hopke (1968) describes ethics as moral obligations determined by

communities. Kidder (1995) acknowledges “There is little to be gained by trying to distinguish between moral and ethics. Some think of the former as personal and the latter as institutional” (p. 64). Since no clear definition is apparent, this research will delineate morals from ethics. Morals will refer to individual values. Ethics are standards and values that communities determine, such as those delineated in a code of ethics.

Ethics relates to the decisions made in a particular circumstance. Harris (2008) refers to ethics as the “moral quandaries” that confront people. Harris (2008) becomes more specific about ethics as he writes “our view of what is right and wrong is an expression of our moral philosophy and our beliefs about the proper relationship between the individual and society” (p. 5). Ethics involves beliefs and relationships that we build in our lifetime.

Not all decisions have an ethical basis. It is the philosophical position that makes the ethical choice different. When the choice is not in conflict with other competing courses of actions, then the choice may be easy to accept. It is a choice between right and wrong that poses an ethical dilemma.

Ethical Dilemmas

When a choice has two conflicting resolutions that are both considered to be right, this situation is called a dilemma. Gibson (1993) defines an ethical dilemma as a situation that “involves choices between conflicting values, issues or principles, which result in two equally unsatisfactory alternatives” (p. 2005). Gibson (1993) recognizes that ethical dilemmas are not solved by theory nor reasoning alone, but these act as frameworks. Shea (1978) describes a dilemma as a choice that has no acceptable resolution. Some negative consequences can be seen as the result of the decision. Merriam and Caffarella (1999) write, “Ethical dilemmas are dilemmas because of this complexity in thinking about what constitutes right and wrong. There

are no simple answers. An ethical dilemma forces the choice between competing courses of action each with its own values" (p. 372). Brockett (1988) quotes from authors' (Purtilo & Cassel, 1981; and Wooten & White, 1983) description of ethical dilemmas that entail a conflict of values.

Kidder (2005) defines an ethical dilemma as a situation where "two deeply held values are in opposition" (p. viii). A right versus right situation is even more difficult to determine the appropriate course of action. For example, if the RCP has a high degree of confidence that an elderly patient needs supplemental oxygen at home, but the patient does not qualify through Medicare (and the patient cannot afford to purchase the oxygen), does the RCP falsify documentation so the patient does qualify? However, ethical dilemmas may arise that place the RCP in a dilemma where both solutions are right. Once the situation is deemed to be a right versus right dilemma, the practitioner must undertake a process that allows a decision to be made. Kidder (1995) would next identify the paradigm which the decision would be made.

These paradigms are (a) justice vs. mercy, (b) short - term vs. long - term, (c) truth vs. loyalty, and /or (d) self vs. community. The paradigm of justice refers to situations where the practitioner relies on the rules associated with the situation. The paradigm of mercy relies on the practitioner relying on compassion and sympathy for making a determination in specific situations. When an ethical dilemma can be framed with short term or long term consequences the practitioner makes determinations as to the best outcomes in these time frames. If the ethical dilemma falls within the truth paradigm, the practitioner's decision is based upon fact and certainty. The loyalty paradigm pertains to the practitioner's devotion to a particular entity when making a choice in an ethical dilemma. In the self versus community paradigm, the practitioner

weighs the consequences of action as to what is best for the individual against what is best for a community. According to Kidder (2005)

The point behind the justice – versus – mercy paradigm is that fairness, equity, and even – handed application of the law often conflict with compassion, empathy, and love. Short – term versus long – term, or now versus then, reflects the difficulties arising when immediate needs or desires run counter to future goals or prospects. The individual - versus – community paradigm can be restated as us versus them, self versus others, or smaller versus larger groups. Truth versus loyalty can be seen as honesty or integrity versus commitment, responsibility, or promise-keeping. (p. 90)

These paradigms determine that a right versus right situation exists. Once the situation fits into one of these paradigms, then the practitioner can help solve the dilemma by using a care based, rule based, or ends based approach to the dilemma.

Kidder (1995) uses the care based, rule based, and ends based approach as the lenses in which practitioners are to make decisions. He has taken the various theories such as deontological theory, utilitarianism theory, intuitionism theory, and emotivism theory, and converged them into care based, rule based and ends based approaches. In the care based approach the practitioner looks through the lens of love and compassion to make the decision. Kidder (2005) sees this as the “Golden Rule” approach. The practitioner will make the decision based upon what the practitioner would want others to do for them. Rules and regulations are the lens the practitioner looks through to make decision in the rules based approach. It is not the result that the decision maker considers, but the rules that are followed. In the ends based approach, it is the anticipation of the end result that determines the decision. The ends justify the means by which the decision is made.

The practitioner will use the care based, rules based, or ends based framework depending on where and what ethics were learned. In other words, the framework that the practitioner views the dilemma will be based upon their values. Hill (2004) acknowledges that these philosophical perspectives are value laden, and the practitioner would enhance ethical decision making by understanding the framework which they make decisions.

Ethical Decision Making in Selected Professions

In adult education as well as other professions, decision making models exist, but have not been tested. And there do not appear to be any studies on how adult educators make decisions in an ethical dilemma. Consulting the literature from other professions may offer some approaches as to decision making and ethical dilemmas.

For example in the area of business, ethics is a part of the curriculum. Wines (2007) write, “Much attention is paid in both the classroom and in the literature to the issues of moral decision-making faced by the individual” (p. 487). Decision making models do exist in business, but empirical evidence is lacking. Carroll and Buchholtz (2008) describe an ethical decision making model for business. This model begins with steps and then has the practitioners choose an approach to engage in a course of action. There are even arguments whether ethics should be taught in business school. As Wine describes,

One line of argument holds that there is no use in trying to teach ethics at the college or graduate level because it is simple “too late” if students do not know the difference between right and wrong. A variant of that argument states that business ethics cannot be taught as long as business educators refuse to examine the ethical foundations of their basic model. (p. 483)

Like the business profession, the field of law also is concerned with ethical issues. Professional lawyers have a strong code of ethics. Gunz and Gunz (2008) describe lawyers “as members of professional bodies that police their conduct, they are sworn to abide by the ethical code of their profession that goes well beyond what the law requires” (p. 927). Gunz and Gunz (2008) researched professional behavior within the law profession in which an area of the research pertained to ethics. These ethical issues did not identify an ethical decision making model or process, but instead looked at possible identities that lawyers may choose to decrease the chance for subjectivity in their responses. Gunz and Gunz (2008) did reference a decision making model in law, but did not pursue the ways in which practitioners learn to make these decisions. Other professionals such as physicians are concerned about ethical dilemmas that they may face in practice.

With advances in medicine, physicians deal with ethical issues routinely. According to Illinworth and Parmet (2006)

Concern about the social and ethical implications of health care practices and biomedical advances is everywhere. From discussions about partial-birth abortion to debates about stem cell research, one cannot escape controversies about moral quandaries that arise at the forefront of modern medicine. (p. 1)

From a literature search, one qualitative research article was found addressing ethical problems that general practitioners encounter in Australia. According to the author, Braunack (2001), the purpose of this qualitative research was to differentiate how lay people define ethical dilemma in the literature and how general practitioners define ethical dilemmas. Nothing in this research clarified the way general practitioners make medical ethical decisions. Other professions attempt to address some of the issues of ethical medical decision making.

Like other health care professions, physical therapists come in contact with ethical dilemmas in their practice. Finch, Geddes, and Larin (2005) write, “ the identification and consideration of relevant ethical issues in clinical decision making, and the education of health care professionals (HCP) in these skills are key factors in providing quality health care” (p. 147). Finch, Geddes, and Larin (2005) researched ethical decision making in the profession of physical therapy. They (2005) developed a qualitative study in Canada that addresses ethical decision making and concluded, “PTs readily identify dilemmas that involve an ethical decision, but they do not generally identify the ethical principles involved or use an ethical approach to analyze the problem” (p. 160). These researchers did note that future research is needed in ethical decision making. Finch, Geddes, and Larin (2005) state “Future research could also explore how HCP students learn about ethical decision making in clinical placements” (p. 160). There is another profession where decisions about ethical dilemmas are also a part of that professions daily practice.

Ethics and Adult Education

Since this study is about learning and ethical decision making, an appropriate area to examine and to inform this study is adult education. Adult educators are often faced with decisions that are of an ethical nature. Some adult educators have addressed the ethics of the adult education field, but empirical research is very sparse. Most of the available writings about ethics in the field of adult education are anecdotal or perhaps in some cases theoretical. Singarella and Sork (1983) wrote that little has been written in the literature regarding ethical issues in adult education. Now, thirty years later there is still little empirical research surrounding the issues of ethics and adult education. McDonald and Wood (1993) write, "Most literature on ethics in adult education focuses on individual writers' discussions of ethical issues as they

pertain to adult education, higher education, consulting, and organizational development" (p. 243). Brockett (1988) reinforces this notion by recognizing the importance of ethics in adult education, but the lack of emphasis in the literature. Gordon and Sork (2001) agree that empirical research is virtually nonexistent regarding ethics in adult education.

Ethics permeates all areas of adult education and adult learning. Curriculum developers, program planners, facilitators, educators, human resource developers, and adult learners deal with ethical dilemmas routinely. For example, ethics is vital in program planning. In today's world, it is becoming more apparent that adult education needs to behave more like a business. Adult education has a cost associated with it. Educators must show the benefit for education. Sork (1988) states,

The pressure to get the job done, to conform to the institutional policies and practices, to accept established norms, and to respond to the needs of the clients, all make it difficult to question the moral basis for decisions made and action taken. (p. 44)

Even in areas where no apparent ethical considerations seem apparent, they are evident. Curriculum and program planning seem to be ethically neutral on the surface, but upon deeper inspection ethical biases exist. For example, whenever power relationship exists, then planning becomes an ethical necessity. Cervero and Wilson (1994) write,

Ultimately, planners have to take a stand about who will represent which interests in making the judgments about the purposes, audience, content, and format of the program. Because planners always have to decide who will represent which interests, they need to attend to the ways in which power relationships among people strengthen certain interests and silences others. (p. 164)

Approaches relating to ethics in adult education stem from the deontological, teleological, intuitionism and emotive theories (Burns & Roche, 1988; Carrol 1996; Davis, 1997; Edge & Groves, 1994; Frankena & Granrose, 1974; Jarvis, 1995). Other approaches exist also. Lacznia (1983), for example, describes other principles such as the utilitarian principle, professional ethics, the golden rule, Kant's categorical imperative and the TV test.

However, the most common ethical approaches described in the literature derive from the deontological, teleological, intuitionism, and emotivism theories. The deontological theories are based upon ideas that moral action is the fulfillment of duty and obedience to a set of rules (Jarvis, 1998). Davis (1997) writes, "Many people profess to believe that acting morally, or as we ought to act, involves the self-conscious acceptance of some (quite specific) constraints or rules that place limits both on the pursuit of our own interests and on our pursuit of general good" (p. 295). In order to be ethical, the rules are to be followed. This type of belief is at the heart of the push for a code of ethics in adult education.

Teleological theories are completely opposite to deontological theories. These theories are based upon the greatest good being achieved regardless of the means. Jarvis (1995) describes the teleological approach as "this position states that acts are morally right if they can produce the greatest balance of good over evil" (p. 21). The rightness and wrongness of an act is determined by the consequences (Davis, 1998). Frankena and Granrose (1974) state, "our ultimate obligation is to secure the increase and to prevent the decrease of the present amount of good, and to secure the diminution and check the increase of the present amount of evil" (p. 100).

Intuitionism asserts that ethical principles are innate and instinctively known (Schneewind, 1998). Ethical decisions are based on instincts, ethics is self evident, and no

justification is necessary. Regarding intuitionism, Jarvis (1997) writes, “people make ethical judgments intuitively, or as if the answers to the ethical questions are self-evident, so that they do not need any further justification” (p. 23).

Emotivism is placing language at the core of ethics in order to influence behavior. Rachels (1998) states that “According to emotivism moral language is not fact-finding language; it is not typically used to convey information. It is used, first, as a means of influencing people's behavior. And, second, moral language is used to express (not report) one's attitude” (p. 337). To put it simply, language is used to motivate people to act ethically.

These approaches place ethics in different aspects of human behavior. Deontological ethics is concerned with following rules, teleological ethics are concerned with consequences, intuitionism is concerned with instincts, and emotivism is concerned with communication. Even though Jarvis (1997) writes about deontological, teleological, intuitionism and emotivism theories, he describes these approaches in terms of relationships that is at the core of ethics.

Jarvis (1997) takes a unique approach to ethics in adult education. He describes relationships as the principle aspect of ethical considerations. Jarvis describes relationships with the “Other.” The “Other” can be a living being, an individual person, or a spiritual being. According to Jarvis, once the “Other” comes into contact with us, then an ethical relationship begins. Starratt (1994) supports the position stating we have a sense of responsibility that urges us to think of others. The ethical person is connected. Jarvis (1997) states, “It is significant that whatever the relationship, whoever the people and whatever the historical time, this argument still applies. It is for these reasons that it can be claimed that the basis of moral value is that it is universalisable” (p. 35). The “universal good” that Jarvis describes is caring for the “Other.”

Jarvis applies this ethical relationship to training, teaching, self-directed learning, distance learning, and mentoring. Summarizing this perspective, Jarvis (1997) writes,

What is called for is an approach to learning that enables people to recall their own experiences of being cared for, and their experiences of caring for others, and realising that the world would be a better place - irrespective of either social structures or social change - if individuals living within whatever structures that exist do so out of the concern for the Other. (p. 171)

Ethical Decision Making Processes

Most that is written on ethical decision making in adult education is related to the “process” of ethical decision making. For example, Brockett (1988) describes a process for ethical decision making that underscores the complexities that are inherent in professional practice. This process differentiates among the dimensions of ethical practice. At the core of the process is a personal value system with consideration of multiple responsibilities encompassing this core. According to Brockett and Heimstra (2004), value systems “form the beliefs that, consciously or unconsciously, educators carry with them in their practice” (p. 14). It can be argued that not only educators carry these beliefs in their practice, but professionals in general operate from beliefs based on a value system. The inner dimension refers to the various responsibilities that professionals possess. These responsibilities may be to the institution, professional organization, stakeholders, and to themselves. The outer level consists of operationalization values. Operationalization values are the place where practice and values meet. In the daily routine of a RCP, the RCP’s core values and the institutions policies will influence the decisions made at the bedside.

Miller and Davis (2004) describe an ethical decision making process. This process helps counselors make ethical decisions in various dilemmas. The process consisted of identifying the problem, applying a code of ethics, determining the nature of the dilemma, generating a course of action, considering potential consequences in all of the courses of action, and evaluating the selected course of action. Other authors describe similar processes (Healy, 2003; Cottone & Claus, 2000; Mattison, 2000; Corey, Corey & Calianan 1998; Steinman, Richardson, & McEnroe, 1998; Forrester-Miller & Davis 1995; Keith-Spiegel & Koocher 1985). Some of the differences in these authors decision making process were associated with the steps involved in the decision making process. For example Corey, Corey, and Calianan's (1998) process did not include reflecting on the process after a decision was made. Forrester-Miller and Davis' (1995) process did not involve communicating with peers regarding decision making.

Many authors believe that the decision should involve a step by step process (Merriam & Caffarella, 1999; Carroll, 1996; Edge & Groves, 1994; Starratt, 1994; Brockett, 1988; Laszniak, 1983; Shea, 1974; Sork, 1988). Shea (1974) has the most detailed approach to ethical decision making. Shea, for example, describes a step by step process for ethical decision making. His steps include 1) the need to make ethical decisions, 2) the opportunity to make an ethical decision, 3) recognition of the lens through which the ethical decision is being made, 4) information gathering, 5) dealing with the consequences, and 6) reflecting on the action of the decision. These scholars (Carroll, 1996; Edge & Groves, 1994; Laszniak, 1983; Merriam & Caffarella, 1999; Shea, 1974; Sork, 1988; Starratt, 1994) each describe steps to ethical decision making similar to Shea's model. Their processes may combine several steps or exclude steps to ethical decision making. Brockett's (1988) model was a little different.

Fremgen (2012) offers a three step model and a seven step model. The three step model involves asking three questions: (1) is it legal, (2) is it balanced, and (3) how does it make me feel. The seven step model is similar to other models beginning with identifying the problem, deciding the ethical issue, identifying the ethical principles, identifying alternatives, comparing alternatives, assessing consequences, and making the decision. Fremgen (2012) also describes a clinical model for healthcare practitioners. This model includes gathering information, clarifying the ethical issues, and resolving the dilemma.

Brockett's (1988) approach emphasized the importance of reflecting on the decision making process. He recognizes that practitioners need to reflect on the ethical content of their decisions so that future dilemmas can be resolved with more certainty. When RCPs make decisions in ethical dilemmas, it may be unknown at the time the consequences of that decision. It is vital for practitioners to reflect on decision making process and the consequences of the actions so that better decisions can be made in the future. Looking back on the situation and analyzing it should help with future decisions.

The ability for a practitioner to apply reflective analysis is important to ethical decision making. Writing about decision making in nursing, Fedorka and Husted (2004) state, "A nurse's basic process occurs when she analyzes her life as a nurse. Her most rewarding process of ethical analysis may occur when she examines her life as a nurse with a view to making her profession maximally worth living" (p. 52). Reflective analysis that occurs in a practitioner's life may allow them to better understand their moral development and apply that to ethical dilemmas. But, more importantly, reflective analysis should occur within the practitioner's practice. Leppa and Terry (2004) write, "Reflective practice is equally relevant to nurse clinicians, who have been encouraged to reflect on the way they deliver care so as to identify weaknesses" (p. 195). Not

only should practitioners reflect on the way they deliver care, but just as importantly they should reflect on ethical decisions that are made.

Schön's (1983) idea of reflection – in – action is to have the practitioner reflect on the surroundings and everything associated with them. In general, Schön describes the practitioner who frames the problem or situation, constructs a solution, mentally tests the solution, interprets the outcome, intervenes into the situation with the solution, and evaluates the outcome. The processes that practitioners use vary with the severity of the situation. In general, however, the practitioner will frame the problem or situation, construct a solution, mentally test the solution, interpret the outcome, intervene into the situation with the solution, and evaluate the outcome. This is what Schön called reflective practice. McAlpine, Kristjanson, and Poroch (1997) support Schön's reflective practice when they write, "There has been consistent recommendation by theorists, educators, and researchers that education programmes fostering reflective thinking about ethical issues be a part of curricula" (p. 1151). Not only does reflection need to happen in the RCP's practice, but also the principles that the RCP looks at the ethical situation with needs reflection.

Sork (1988) suggests that practitioners need to examine their ethical principles and the application of these principles to prevent social or personal injustices. Through reflection, practitioners may be able to analyze good decisions and reinforce that decision for future consideration. As much as practitioners try, not all decisions made in ethical dilemmas are good decisions. Unexpected outcomes may turn what was considered early in the decision making process as a good decision into a bad one. Practitioners are obligated to review their ethical principles, the process that is chosen, the circumstances, and the outcomes with decisions that are made in the clinical environment.

Ethics in Respiratory Care

What do ethics have to do with patient care? It is the responsibility of RCPs to make good decisions in caring for patients. Speaking of healthcare practitioners making good decisions, Pozgar (2013) writes,

We study ethics to aid us [healthcare professionals] in making sound judgments, good decisions, and right choices. If not right, then better ones. To those in the health care industry, it is about anticipating and recognizing health care dilemmas and making good judgments and decisions based on universal values that work in unison with the laws of the land and our Constitution, and where the law is silent, we rely on the ability of caregivers to make right judgments as guided by the wisdom of Solomon to do good. (p. 3)

Many situations exist in medical practice where RCPs must make decisions in ethical dilemmas. One area where a RCP may need to make an ethical decision in a specific situation is when life support is terminated. When a patient is deemed to be in a persistent vegetative state, life support may be ordered to be discontinued. It is the responsibility of the RCP to discontinue mechanical ventilation knowing that it is likely the patient will die. The sanctity of life issue conflicts with the quality of life issue. The RCP will need to make a decision as to whether to follow the physician's order or relinquish the responsibility to someone else. A policy may indicate what the RCP is to do after the ethical decision is made, but does not help with the decision itself. Hospital routinely have policies that allow a staff member to request not to participate in aspects of care that will conflict with the health care provider's cultural values, ethics, or religious beliefs.

In the everyday routine of RCPs, medical dilemmas arise frequently where ethical decisions need to be made. A RCP may have limited equipment resources regarding patient monitoring. Also, a RCP may be tempted to falsify documentation to the benefit of the patient. Medicare and Medicaid guidelines are very strict for payment of supplemental oxygen. When two or more patients need the same piece of equipment, the RCP must make the decision as to which patient will receive it. The RCP's two to four years of formal education may touch on medical ethics, but does it prepare the RCP to make ethical decisions that arise in medical practice? During the thirty to forty years on the job, how do RCPs identify ethical dilemmas where decision making is necessary and how do RCPs learn how to respond when faced with a decision that involves medical ethics? The problem is that RCPs frequently face dilemmas where medical, ethical decisions are necessary with little formal training in how to solve dilemmas where ethical decisions need to be made.

Just as other professional fields have a code of ethics, so does the field of Respiratory Therapy have a code of ethics (Appendix A). A code of ethics has been accepted by the American Association of Respiratory Care, while a code of ethics has not been accepted in the field of adult education. There is an expectation that people are abiding by this code even though they are not learning about it in education and training. In order to help curriculum developers in Respiratory Therapy with continuing education, they need to know exactly how people make decisions. How are people employing this code of ethics? One of the places where adults who are RCPs learn about their practice is continuing professional education (CPE).

Continuing Professional Education

Often times what happens in a formal classroom environment does not prepare a professional in today's world of practice. CPE helps to do that. CPE is described as many

different types of educational endeavors. From formal learning to contextual learning to self-directed learning, reflection on practice, and learning from mistakes, the concept of CPE has evolved. Houle (1980) writes “The explosion in terminology to describe professional education reflects maturing from the days of rudimentary craft practica to that which relies on mastery of sophisticated concepts and techniques” (p. 88). CPE should encompass many different learning endeavors. Cervero (2001) expands on Houle’s description as he writes that CPE is “difficult to describe accurately the landscape of continuing education” (p. 19). Daley and Mott (1980) describe CPE programs that should “support professionals in dialogue and collaborative inquiry, encourage practice-based and practice-sensitive research and foster the development of professional expertise and improved practice in the profession, thus enhancing both work and learning” (p. 83).

CPE is not only important to the professional, but also to the company or institution to which the professional belongs. To see this importance of CPE to companies one only need to examine the costs of CPE to those companies. Daley (2001) writes, “employers and professionals spend billions of dollars annually on professional development programs” (p. 40). I worked in a 550 bed acute care center in a community of less than 100,000 people that employed 120 educators. Each area in this acute care facility had at least one educator. With an average hourly wage of \$25.00 per hour, this facility paid over \$500,000 per year for educators. These educators presented information to the hospital staff in various educational forums. One seminar was presented on medical ethics. However, no evidence was found that any other continuing education was provided on decision making and ethical dilemmas. Only two seminars were presented in the twenty years I practiced that related to ethics. These seminars were general in

relation to ethics and did not offer practitioners ethical decision making models that would help solving medical, ethical dilemmas.

One educational format of CPE is formal learning. Whenever technology changes, new equipment is introduced, or new advances are made in medicine, in-service education is provided so professionals can learn of this new information in their individual institutions. Cervero, (2000) acknowledges that this type of formal learning is “devoted mainly to updating practitioners about the newest developments” (p. 4). Formal learning is important in disseminating this type of information. On a broader scale, other professional forums are used to equip the larger population of professionals with advances. In the twenty years I was the educational coordinator, many in-services were presented in relation to new equipment and procedures, but no in-service education was presented that dealt with making decisions in ethical dilemmas.

Most medical professionals who possess a license must maintain a certain number of Continuing Education Units (CEUs). The various medical associations dictate the number and type of CEUs are required to possess a license. Most CEUs that are required must be obtained through a formal learning endeavor. This learning endeavor is usually in the form of a seminar. Daley (2000) recognizes that these types of CPE program “are more effective in teaching novices than in fostering the professional development of experts” (p. 33). RCPs not only need to learn about changes in their profession, but must continuously acquire knowledge about the ways their practice impacts the patient. In 2007 and 2008, 108 continuing education hours were offered for RCPs by Georgia, Alabama, Tennessee, South Carolina, and Florida, states that have licensure. Not one of these 108 hours was dedicated to ethics.

Eraut (1995) explains the importance of professional knowledge, professional competence and the accountability of each. Professional knowledge is created not only in higher

education, but also in professional practice. Eraut would say that practice stimulates higher education to provide or “find” the research that matches what the practitioner finds in his/her practice. Professionals need to reflect on their experiences as a basis for future events and critically examine established rules.

Eraut supports Benner’s (1984) case for the expert when he describes the need for the “mid-career professional” to continue learning on the job and help disperse this knowledge to others. He describes the difference between technical knowledge and practical knowledge. Technical knowledge is the knowledge gained in a systematic, arranged way. This type of knowledge can be learned on the job or in a higher education level. Practical knowledge is that knowledge that can only be obtained through practice. Eraut (1985) writes, “The effectiveness of most professionals is largely dependent on the knowledge and know-how they bring to each individual case, problem or brief. Much of this knowledge comes from experience with previous cases, so its use involves a process of generalization” (p. 121). Professional knowledge can be gained through the RCP’s practice, but the RCP must be aware of the educational experience when it presents itself. Opportunities exist for ethics and decision making in professional practice in the form of practical knowledge as long as the practitioner is attuned to the experience.

Clinical experience presents itself in many ways, and the practitioner must learn in different ways to benefit from the potential learning experience. For RCPs, the clinical environment offers an opportunity for knowledge to occur. Practitioners cannot be one dimensional in the way of learning. Daley (2000) identifies the need for educational programs to improve “the quality of client outcomes within the profession” (p. 81). This improvement as Daley (2000) views it will be accomplished through expanding CPE to a “practice centered role”

(p. 81). In other words CPE must take into account the significant learning that takes place at the patient's bedside to help the practitioner understand the things that he is experiencing.

In the clinical setting, learning opportunities occur in non-specific moments. Contextual learning allows practitioners to make sense and understand what is going on. If the practitioner can make sense of what is going on, then the chances increase this knowledge can be used in the future with other patients. Ng and Cervero (2005) describe the importance of learning in context. Professionals take experiences in socialized environments, make sense out of them, and store them for possible use at a later time. Eisen (2001) concurs when she writes, "context-specific issues are important because most learners, particularly busy professionals, are motivated to solve real – life problems" (p. 9).

Eraut's (1985) conceptual framework of continuing professional education involves context. Eraut challenges the idea that theory is context free and practical knowledge is context bound. Situations will dictate the context, not knowledge. Three types of context are identified: academic context, policy context, and professional practice ("action context"). Academic context refers to the didactic part of learning where papers, essays, and examinations are important. The formats of these exercises dictate the general pattern for knowledge's use. In the policy context, knowledge is for public debate. The interaction with peers, clients, and other professionals require a skill to relate to other's ideas. Professionals must decide what knowledge is important and must be able to debate with others the ideas they wish to convey. Action contexts involve being proactive in given situations. As Eraut (1985) points out, "Unlike the academic, the practicing professional is in a 'what ought to be done' environment" (p. 137). Others support the importance of CPE in learning in context (Cervero 1992; Daley and Mott, 2000; Mott, 2000; and Hansman, 2002).

Reflecting on the professionals' practice is important in CPE. Eraut (1985) recognizes that professionals

can both (1) reflect on their experiences, make it more explicit through having to share it, interpret it, and recognize it as a basis for future learning; and (2) escape from their experience in the sense of challenging traditional assumptions and acquiring new perspectives. (p. 118)

The type of knowledge that Eraut (1985) describes is different from the knowledge found in formal education. This notion of a two knowledge systems is supported by Schön (1987). Mott (2000) acknowledges that "Much of the learning that takes place in one's profession comes about in response to the problems of the practice itself" (p. 28). Learning through reflection, allows the practitioner to understand what Schön (1987) describes as the "swampy lowland, messy, confusing problems" that confronts practitioners. Schön described reflection in action as

When we go about the spontaneous intuitive performance of the actions of everyday life, we show ourselves to be knowledgeable in a special way. Often we cannot say what it is that we know. When we try to describe it we find ourselves at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinary tacit, implicit in our patterns of action and in our feel for the stuff with which we are dealing. It seems right to say that our knowing is in our action. (p. 49)

It is in the professional context described by Eraut (1985) where RCPs are most likely to learn how to make decisions about ethical dilemmas. Since continuing profession education expands all professions, we need to look specifically at CPE in relation to Respiratory Care Practitioners. It is through the professional practice context described by Eraut where RCPs appear to have the greatest opportunity to learn how to make ethical decisions about ethical dilemmas.

RCPs and Continuing Professional Education

RCPs have numerous opportunities for continuing education. In order to take the National Board for Respiratory Care Exams, the prospective graduate must earn an Associates Degree in Respiratory Therapy. After graduation, RCPs must decide the type of environment that they wish to work. Most RCPs choose acute care facilities to begin their profession. If the RCP works in an acute care facility, then the facility will provide for continuing education.

In the initial stages of employment, the RCP will enter an orientation period to help with the transition to the facility and the policies and procedures involved in the practice. In the hospital environment, the goal of orientation is to familiarize the new employee with the policies and procedures of Respiratory Care Services. The orientation process is also used for the employee to perform techniques under direct supervision prior to performing them independently. The RCP will be placed with a mentor to ensure that the new RCP is competent and can manage the workload. Most institutions will provide other forums for the RCP to gain knowledge.

One educational forum that institutions use includes in-service education. Routinely RCPs are assembled and taught new techniques. The RCP will perform the new technique under expert supervision and in a controlled environment. In-service education is also where new equipment is introduced. RCPs are trained with the equipment before it is used in the patient care areas. In the Respiratory Therapy Policy and Procedure Manual at the Medical Center of Central Georgia policy 1-110 (2009) states that the application of new equipment will be “presented with material at planned meetings by qualified personnel in the use of the new equipment.”

Competency workshops are employed by some institutions to ensure that the RCP is competent with procedures. The workshop allows RCPs to perform procedures under expert

supervision to ensure that the RCP maintains competency. The procedures are usually a high liability and performed infrequently in the patient care environment. The RCP will also perform complicated procedures to ensure competency. Not only are competency workshops available to RCPs, but progressive institutions will provide routine seminars to keep RCPs abreast of the latest procedures.

Respiratory seminars may be held by the RCPs employer so that RCPs can learn of the latest technology that is beneficial to their institution. These seminars are beneficial to RCPs in the institution because the seminar is tailored to the RCPs work environment. The employer may also provide CEUs for the RCP.

RCPS also have multiple local, state, and national meetings that allow for anywhere between three and five education opportunities annually. These meetings are more generic in regards to the information provided to the RCPs. Usually these meetings are one to three days in length and provide the RCP with a substantial number of CEUs that are required for licensure.

In many institutions, RCPs may have access to library resources and internet resources. The main use of library resources are peer reviewed journals. Peer reviewed journals allows RCPs to broaden their knowledge base to information that is of interest to them. Internet resources are also available in many institutions' library. The internet allows RCPs to review a variety of subjects of interest. Internet conferencing is also available to help clinicians with patient care problems. Because the field of continuing professional education does not have studies to show how professionals make decisions, we need to look at the literature on decision making particularly about decisions involving ethical dilemmas.

Summary

In nearly every profession, practitioners are faced with situations where they are to make appropriate decisions in ethical dilemmas. Respiratory Care is such a profession. Models of ethical decision making in adult education and other professions have been explored. No research is available on their effectiveness of learning in adult education, other professions, and Respiratory Care. Other professions have anecdotal stories regarding ethics and processes that are untested. Where do RCPs learn to make decisions in ethical dilemmas? The literature demonstrates that professionals make decisions involving ethical dilemmas and although the literature includes models of decision making, this researcher was unable to locate any literature that demonstrates how RCPs learn to make these decisions. Multiple opportunities could exist for learning how to make decisions in ethical dilemmas such as in formal education, continuing education, and in practice. For RCPs, none of these offer planned, systematic education about making decision in ethical dilemmas. Yet, RCPs make these decisions.

CHAPTER 3

METHODOLOGY

The purpose of this study was to understand how Respiratory Care Practitioners (RCPs) learn to make decisions in ethical dilemmas in their practice. The study was guided by the following research questions:

1. Under what circumstances do RCPs engage in decisions involving ethical dilemmas?
2. What is the learning process for RCPs who engage in making decisions in ethical dilemmas?
3. How do contextual factors influence decision making in ethical dilemmas for RCPs?

The purpose of this chapter is to describe the research methods used in the study. This chapter is organized with the following sections: Design of the Study, Sample Selection, Data Collection, Data Analysis, Validity and Reliability, Researcher Assumptions and Biases, and Summary.

Design of the Study

To investigate decision making in ethical dilemmas by RCPs, the participants should be able to describe this phenomenon within a contextual framework. Merriam (2009) writes, “Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 5). In order to determine the circumstances for ethical decision making, the learning process, and the contextual factors involved, qualitative research will allow the researcher the tools to describe the RCPs experiences in the clinical environment. Also, qualitative research has five

characteristics that will allow the researcher the ability to gain an understanding of how practitioners learn to make these decisions.

According to Merriam (1998), the key philosophical assumption of qualitative research is that it “is constructed by individuals interacting with their social worlds. Qualitative researchers are interested in understanding the meanings people have constructed, that is, how they make sense of their work and the experiences they have in the world” (p. 6). Since most of the literature regarding ethical decision making involves anecdotal experiences and ethics is sometimes a vague concept, qualitative research should be an appropriate research method to gain an understanding of how practitioners learn to make these decisions. Also, RCPs are making medical decisions in ethical dilemmas in a clinical environment and as Creswell (1998) points out, “qualitative researchers study things in their natural settings, attempting to make sense of a phenomena in terms of meanings people bring to them” (p. 15). Marshall and Rossman (2006) support this view when they write, “Thus, qualitative research is pragmatic, interpretive, and grounded in the lived experiences of people” (p. 2).

A second characteristic of qualitative research is the principle instrument for data collection and analysis of that data is the researcher. Merriam, (2009) writes that the “researcher is the primary instrument for data collection and analysis” (p.15). In order to obtain the participants perspective in decision making in ethical dilemmas, I conducted semi-structured interviews and recorded responses. With semi structured questions, I inquired as to the type of ethical dilemma the participant engaged in and the specifics of the decision making. During the interview process, I asked additional questions to clarify the respondent’s answers. I taped and transcribed the interview. The transcription was entered into a word document and analyzed.

Another characteristic of qualitative research is that it usually involves some kind of field work. In fieldwork, the researcher is present in the environment where the phenomenon takes place. Having been in the clinical environment for over twenty years, I have come to realize that context is extremely important when describing events in the clinical setting. The participants of this research described ethical dilemmas and decision making in the context of the clinical environment. I conducted interviews in the institution where the RCP has experienced an ethical dilemma or in the participants' home. As the RCP answered questions, I observed and took notes to help with analysis.

A fourth characteristic of qualitative research is that it employs inductive reasoning. Very little empirical evidence exists in the literature regarding making decisions in ethical dilemmas. Merriam (2009) writes, "Often qualitative researchers undertake a qualitative study because there is a lack of theory or an existing theory fails to adequately explain a phenomenon" (p. 15). I gathered data and built concepts and themes through the stories of the participants.

The last characteristic acknowledged by Merriam (2009) is that the research is richly described. The participants' words, actions, meanings, and feelings are to be used in data collection and analysis. The ethical dilemmas were placed in context with the participants' involvement and interests. In this study I used the actual words that the participant employed to describe the ethical dilemmas and how they came to make the decisions. From the spoken words of the participants and my field notes, I was able to clarify the themes and categories that emerged from the data.

In order to best answer the questions posed in this research, the basic or generic qualitative research approach was employed. Merriam (1998) calls the generic approach the most common approach, and it seeks to discover a process with the perceptions and worldviews of the

people involved. The research is intended to describe the lived experiences of RCPs regarding decision making with ethical implications. RCPs routinely make these decisions and were able to describe the process and how they came to learn to make these decisions.

Sample Selection

As Marshall and Rossman (2006) point out, “One cannot study the universe – everything, every place, all the time. Instead the researcher makes selections of sites, samples of times, people, and things to study” (p. 62). Since the goal of this research was to understand how RCPs make decisions in ethical dilemmas, a purposeful sample was necessary. Merriam (2009) writes, “Purposeful sampling is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (p. 61). The participants chosen have experience with ethical decision making and are able to describe their experiences. Patton (2002) describes the logic and power of purposeful sampling. Patton (2002) states,

The logic and power of purposeful sampling derive from the emphasis on in-depth understanding. This leads to selecting information-rich cases for study in-depth.

Information cases are those which one can learn a great deal about issues of central importance to the purposes of the research, thus the term purposeful sampling. (p. 46)

The participants of this study came from three acute care facilities. These acute care facilities were chosen on the basis of a typical site sampling strategy. According to Patton, (2002), “When a typical site sampling strategy is used, the site is specifically selected because it is not in any major way atypical, extreme, deviant or intensely unusual” (p. 236). The three acute care facilities were located in a southeastern state. Two of the acute care facilities were

from metropolitan areas and one acute care facility was from a rural area. Again, the reason for choosing multiple acute care facilities in various areas was to ensure that many experiences are exposed in large and small acute care facilities and in metropolitan and rural areas. The policies and procedures in a large metropolitan facility may be different than those policies and procedures in a smaller rural hospital. For example, in a large metropolitan facility discontinuation of mechanical ventilation may be a product of organ retrieval which may be routine in patients in these facilities. In rural facilities, organ retrieval may not exist and discontinuation of mechanical ventilation may not be explicitly described in policies and procedures. Also, the resources in a large metropolitan facility will be much different than in a smaller rural hospital. Whereas in larger facilities, equipment is abundant; in the rural setting, facilities may not have the finances to purchase equipment to meet every need of patients.

The participants of this research were selected on the basis of a typical sample. Merriam (2009) writes, “A typical sample would be one that is selected because it reflects the average person, situation, or instance of the phenomenon of interest” (p. 78). Five criteria were adopted for selecting the participants. First, participants must be RCPs. Secondly, participants need to have at least three years of experience. According to Benner (1984), three years is the time it takes a practitioner to move from the advanced beginner stage to the competent stage of development. The competent stage allows the practitioner many of the coping and managing skills that occurs in the clinical environment. Thirdly, participants must have good communication skills according to their supervisor or department manager. In order to obtain a richly descriptive phenomenon, the RCP will need to be able to effectively communicate with the researcher. Fourthly, seventy-five per cent of the RCPs in the state of Georgia are women. In order to reflect the diversity in the field of Respiratory Care, I attempted to interview an equal

percentage of women participating in the research and women who are RCPs. Lastly, forty-five per cent of the RCPs in the state of Georgia are from a race other than Caucasian. Again, in order to reflect the diversity in the field, I attempted to interview the same percentage of non-Caucasians participating in the research as non-Caucasians who are RCPs.

For this study, I asked managers in at least three acute care facilities to recommend participants that met the aforementioned criteria. The more experienced RCPs should have more ethical decision making experiences to describe. It has been my experience over twenty years that novices and advanced beginners are so focused (and overwhelmed) on “getting the job done” that they may not have the experiences needed to provide relevant information. Supervisors were asked for participants who are able to communicate effectively. A RCP who can communicate effectively with other health care professionals should be able to communicate their experiences in rich, thick, deep detail. I also attempted to choose a diverse population that added to the richness of the descriptions of their experiences. I took the list of participants and asked if they would participate in the study.

I made a list of participants who were able to be interviewed. The list included fifteen participants that completely met three out of five of the criteria. This sample included interviewing forty-seven percent females as opposed to the seventy-five percent of females I intended to interview to obtain a diverse sample. Also, only forty percent of the participants were of another race than Caucasian as compared to the forty-five percent I intended to interview.

Three participants were chosen to conduct a pilot study. After interviewing the first three participants, I asked them to recommend other potential participants. Marshall and Rossman (2006) describe this type of sampling by “Identifying cases of interest from people who know people who know what cases are information rich” (p. 71). This sampling technique is also

called snowball or chain sampling. Patton (2002) writes, “This is an approach for locating information-rich key informants or critical cases” (p. 236).

A pilot study was used to help the researcher refine the interview process. Questions and answers were analyzed to ensure rich descriptions of events that should be uncovered. The pilot study helped the interviewer with the flow of questions.

The pilot study also helped determined the appropriate questions to ask. Refer to the Appendix B for a sample interview guide. Participants offered advice on ways to ask questions to produce the best results. The pilot study also allowed the interviewer to ask participants if other questions should be asked to elicit responses. At the end of the pilot study, participants were asked if they knew of any other RCP that may help in the determination of ethical decision making.

After the pilot study and in consultation with my major professor, I did add questions. Then I contacted other participants and arranged a place and time of the interview. The number of participants was determined when the data became saturated with rich, deep descriptions of the phenomenon being studied.

Data Collection

Creswell (1998) describes four basic types of information to collect: observations, interviews, documents, and audio visual. To obtain the information to answer the question in this study, I chose interviews and documentation for data collection. Data collection was obtained in the acute care facilities where the participants are employed or in the participants’ home.

Interviewing

Before beginning the interviewing process, I described my own experiences relating to decision making in an ethical dilemma. Even though this process is usually associated with

phenomenonology, it helped me better understand the process and ask questions that pertained to ethical decision making. Marshall and Rossman (2006) describe this process when they write, “Prior to interviewing, however, the researcher using this technique has written a full description of her own experiences” (p. 105). Once I described my own experiences, audio recorded them, and analyzed them, I gained a better insight into the interview process with the other participants. I recognized that asking questions was going to be a difficult process. Even though I knew the answers to the questions I asked myself, I realized that I may need to probe deeper into the questions I asked the participants. I also recognized that I had to be very cognizant of my question delivery as to not lead the participant in a specific direction.

After analyzing my own experiences, I conducted a pilot study and made arrangements to interview pilot participants. I met with participants at their work or home and had a relatively quiet place to hold the interview. I began interviewing participants. Patton (2002) writes, “We interview people to find out from them things we cannot directly observe” (p. 340). The interview process provided information about those ethical dilemmas that are not directly observed and happened in the past.

A combination of semi-structured interview questions and a conversational approach was used to probe the other participants’ experiences. Educating in the medical field for over twenty years, I used semi-structured questions to help students diagnose and treat patients. Semi-structured questions were used to gain access to the participants’ experiences. A semi structured question is a question that probes a participant’s response in order to achieve clarity of a phenomenon. Patton (2002) describes a combination of interviewing strategies that may help probing of issues. For example, he wrote

This combined strategy offers the interviewer flexibility in probing and in determining when it is appropriate to explore certain subjects in depth, or even to pose questions about new areas of inquiry that were not originally anticipated in the interview instrument's development. (p. 346)

On occasion I had to probe deeper into the question. For example, one participant told me that experience allowed him to make the decision he made. I asked him to describe what he meant by experience. He told me about how he observed colleagues and went into detail what his colleagues had done.

Archival Research or Documentation

The researcher archived potential resources that the participants use to help with ethics and decision making. These resources included seminar records, in-service education records, and CEUs. As Marshall and Rossman (2006) point out, "Minutes of meetings, logs, announcements, formal policy statements, letters, and so on are all useful in developing an understanding of the setting or group studied" (p. 107). Most medical educational seminars have records of topics and participants. I reviewed brochures, handouts, and powerpoint presentations at educational seminars that the participants would have most likely attended. I found no evidence from these documents that gave me a greater understanding of these participants' views regarding ethics and decision making.

Respiratory Therapy departments also keep records of in-service education. I reviewed the in-service education documents that included topics and participants. Many of the participants attended Neonatal Resuscitation training or Pediatric Life Support training which included information regarding ethics. This in-service education provided a potential triangulation that would strengthened the study. Merriam (2009) writes, "One of the greatest

advantages of using documentary material is its stability. Unlike interviewing and observation, the presence of the investigator does not alter what is being studied” (p. 155). These archival documents did not yield useful results in the participants’ view of ethics and decision making.

Data Analysis

Merriam (2009) writes, “Data analysis is the process of making sense of the data. And making sense out of data involves consolidation, reducing, and interpreting what people have said and what the researcher has seen and read-it is the process of making meaning” (p. 175). I interviewed myself first and recorded my responses using a tape recorder. My interview was transcribed and I made notes and observations. After reading the transcription and I made notes that I thought were pertinent to the study. According to Merriam (2009), “As you read through the transcript, for example, you jot down notes, comments, observations, and queries in the margins” (p. 178). I determined that no other questions were needed to address the purpose of the research.

Next, I conducted a pilot study. I chose three participants and asked the semi structured questions. The interview was tape recorded, and I took notes. After the interview, however, I asked the participants if they could think of other questions that may be pertinent to the interview process. No other questions were suggested and no other questions were added to the question matrix at this time.

I transcribed each pilot study’s participant’s interview. By personally transcribing the interviews, I became familiar with the data. I read the transcription and made notes and marked key phrases that answered the research questions. I looked for significant statements about each participant’s experiences and made a list of these significant statements. After reviewing the pilot

data and conferring with my major professor, it was determined that additional questions needed to be made for the other participants.

I followed the same process of the pilot study for the other interviews. After transcribing, relevant information was written on note cards and notes were written on the cards that were relevant to the study. After determining relevance, categories were constructed from the notes and the transcriptions. Applicable phrases were marked and potential categories assigned. The cards were placed in piles according to categories. My major professor and I agreed on categories that were determined from the transcripts, discussions, and notes. Merriam (2009) writes about category construction, “The process begins with reading the first interview transcript, the first set of field notes, the first document collected in the study” (p. 178). These categories reflected the themes taken from the data that the participants shared. All of the grouped experiences were recorded and stored on a hard drive of my computer at home and work. A back up copy was placed on a portable memory drive.

Validity and Reliability

In general, validity is drawing correct conclusions from data. Creswell and Miller (2000) state, “there is a general consensus, however, that qualitative inquirers need to demonstrate that their studies are credible” (p. 125). And Merriam (2009) describes validity as participants’ construction of reality. Triangulation, member checks, peer review, data collection, and determination of researcher biases were employed to ensure validity.

In this research, triangulation included comparing extensive interviews, field notes, and documents. Participants were interviewed and their transcriptions were compared to the goals and objectives in the in-service education documents as to the consistency of the participants’ descriptions. The information contained in the Neonatal Resuscitation and Pediatric Life Support

in-services were consistent with the information that the participants described. Overall, these documents did not provide additional relevant information.

Field notes provided another means for triangulating the data. Even though a tape recorder was used, field notes allowed the researcher to concentrate on what the participant was saying while making sure the interview was going in the right direction. Patton (2002) writes that the notes have four main purposes. The field notes helped the interviewer form new questions as needed. The notes helped the interviewer “make sure the inquiry is unfolding in the hoped-for direction” (p. 383). Taking field notes helped locate important quotations and serve as a backup if the tape recorder malfunctioned. The field notes were compared to the documents and interviews to ensure consistency with the participants’ experiences.

Member checks also strengthened validity. After I recorded, transcribed, and created themes from the participants, I contacted each of them and set up another individual appointment. I asked each to review the transcripts for accuracy. We next discussed the categories and themes that emerged from the data. I reviewed the transcripts in the context of the categories and themes and asked each participant if I was representing their story accurately. Each participant acknowledged that what they described was accurately represented. The member check was to verify that the researcher’s interpretations reflect the experiences of the participant. As Merriam points out (2009) this is the most important determination of misinterpreting the participants’ experiences.

After all of the interviews and discussions with the participants, I asked four experienced RCPs that were external to the study to read the interpretation of the data. I asked if these interpretations seemed reasonable in relation to how they practiced and what they had seen in other RCPs. They agreed that the interpretation of the data was accurate in their practice and

what they had seen in other RCPs' practice. In qualitative study, validity is determined by the richness of the descriptions of the participants and the synthesis of those descriptions. In the clinical environment, many factors may determine the way a RCP makes decisions in an ethical dilemma. The environment is dynamic and a small occurrence may change the way the RCP's perceive reality. Creswell and Miller (2000) write, "Reviewers not affiliated with the project may help establish validity as well as various readers for whom the account is written" (p. 125).

Reliability is the extent in which the findings of the research are replicable. Being a qualitative study, the findings of this research may not be replicated. However, as Merriam writes (2009), "The more important question for qualitative research is whether the research results are consistent with the data collected" (p. 231). Strategies discussed with validity such as triangulation, peer review, and researcher bias ensures consistency of the data collected to the experiences of the participants. An audit trail (log) was used to ensure reliability.

I kept a log to show how the participants were interviewed, the recordings and the transcript record. Also, the follow up interviews, how the data was collected, how the categories were delineated, and how decisions were made are described in the log. The log begins with the self-interview and includes the pilot study and interviews with others. I also logged my reflections along the way. The log served as an audit trail that helped show congruency between the data and the participants' experiences.

External validity is the extent in which the study can be applied to similar circumstances. This is a limitation of qualitative research. Even though practitioners may be able to relate to the participants' responses, this research has no plan to generalize to a specific population. It is the richness of the descriptions, the deepness of the meanings that allow others to take from the study the things that are important to them. The participants are a community of RCPs that may

have similar experiences in practice and may find application of this research in their practice. The rich, deep, description of the participants experiences may aid other RCPS to generalize. Corvey (2003) sums up validity and reliability when she says, “Generalizability is ultimately found within the reader’s perception” (p. 88).

Researcher Bias and Assumptions

I am a RCP with 20 years clinical experience and nine years of educational experience as an instructor. The clinical experience occurred in a 500 plus bed acute care facility, while the teaching experience occurred in a college based respiratory therapy program. I also received clinical experience in a 50 bed rural hospital and provided care to patients within their homes. I am aware of the routines of RCPs in a variety of settings. My biggest bias is that I think I have lived the experiences that the participants of this study may reveal. Being a staff Respiratory Therapist, a manager, and an educator in an acute care facility, I have had the opportunity to reflect on and analyze decision making in ethical dilemmas in my practice. I do not believe that my practice is much different from the practices of other RCPs.

I am a white, middle aged male born and raised in the south. I have my own biases from living in a world where white males make the rules. Being strong willed, I sometimes try to control situations. I have been a member of the American Association of Respiratory Care (AARC) and the Georgia Society of Respiratory Care (GSRC) since 1981. In 2006, I was elected as President of the GSRC. Speaking with practitioners in many different settings, we discuss ethical decision making, and I have formed opinions as to how problems and decision making should be approached. For example, I think that a structured, step-by-step approach with reflection is an appropriate way to make decisions in ethical dilemmas. I may not appreciate another approach to ethical decision making that involves intuition or different cultural

perspective. With my biases, I may try to inadvertently shape questions that may lead the practitioner the way I may think they should go. I may also misinterpret the participants' experiences through my biases. I may think I know what they are saying, but may misinterpret their experiences.

Another bias may be that I have been interested in ethics for a long time. I have learned through the years the many aspects of ethics and ethical decision making. Again, I may misinterpret a participant's experience thinking I know what they are describing.

To diminish the effects of my biases, I asked participants if the interpretations transcribed described their experiences accurately. I listened to the tapes and to determine if I was asking a question in a way that would lead the participants in a specific direction. I reviewed the pilot study with my major professor to make sure they were not biased. Also, my major professor read samples of the transcript to ensure that my questions were not leading the participants.

Summary

The purpose of this chapter was to detail the steps involved to understand the learning that takes place for RCPs to make decisions in situations where ethical issues are present. With the five characteristics of qualitative research, I believe that qualitative research answered the questions posed in the purpose of this research. The qualitative approach also allowed the participants to express their feelings and experiences so that others may glean relevance from these experiences. A total of fifteen participants were asked to respond to questions related to decision making in ethical dilemmas. I decided that interviewing and document review was the best data collection procedures. I developed interview questions (see Appendix B) with collaboration from my major professor. Documents were examined and I compared these documents to what I was reading in the transcripts to the extent RCPs were in educational

experiences associated with ethics. Triangulation was achieved by comparing the interviews with my field notes and educational documents. As a consequence of carrying out the components of Chapter 3, the data yielded three major findings that are described in the next chapter.

CHAPTER 4

FINDINGS

Introduction

The purpose of this study was to understand how Respiratory Care Practitioners (RCPs) learn to make decisions when presented with ethical dilemmas in their practice. This qualitative study included fifteen interviews of RCPs that were considered experts by supervisors. The interviews took place in the institutions in which they worked or their homes. The study was guided by three research questions. First, under what circumstances do RCPs engage in decisions involving ethical dilemmas? Secondly, what is the learning process for RCPs who engage in ethical decision making? Lastly, how do contextual factors influence decision making in ethical dilemmas for RCPs?

In order to best answer the questions posed in this research, the basic or generic qualitative research approach was employed. Merriam (1998) calls the generic approach the most common approach, and it seeks to discover a process with the perceptions and worldviews of the people involved. To investigate ethical decision making by RCPs, the participants should be able to describe this phenomenon within a contextual framework. Merriam (2009) writes, “Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 5).

A purposeful sample was used to determine the participants of this research. The participants of this study came from three acute care facilities. These acute care facilities were chosen on the basis of a typical site sampling strategy. According to Patton, (2002), “When a

typical site sampling strategy is used, the site is specifically selected because it is not in any major way atypical, extreme, deviant or intensely unusual” (p. 236). The three acute care facilities are located in a southeastern state. Two of the acute care facilities are from metropolitan areas and one acute care facility is from a rural area.

All participants were RCPs and had a minimum of three years’ experience. They were chosen by supervisors on the basis of their experience, their communication skills and their willingness to describe ethical dilemmas they encountered.

The first participant was the researcher. Three other participants served as a pilot study. After the pilot study, the researcher made adjustments to the questions to provide for clearer explanations of the participants’ ethical dilemma and added questions that related to any reflective practice that may have occurred.

Fifteen participants were interviewed. A combination of semi-structured interview questions and a conversational approach was used to probe the participants’ experiences. Eight participants were interviewed in the institution where they worked with seven participants interviewed in their home. The documents that I compared to the participants’ experiences were brochures of educational seminars and in-service education records.

All interviews were recorded. Field notes were taken so the researcher could concentrate on what the participants said while making sure the interview was going in the right direction. The researcher transcribed the interviews.

After transcribing, relevant information was written on note cards and notes were written on the cards that were relevant to the study. After determining relevance, categories were constructed from the notes and the transcriptions. Applicable phrases were marked and potential categories assigned. The cards were placed in piles according to categories. My major professor

and I agreed on categories that were determined from the transcripts, discussions, and notes.

After recording, transcribing, and creating categories, the participants were asked to review the findings of the researcher.

Participants

Fifteen participants were interviewed. The participants worked in acute care facilities in rural and urban hospitals in the southeast. The average number of years' experience for these RCPs is 20 years. The range of experience is from 4 years to over 30 years. Eight participants earned a Bachelor of Science degree, four earned an Associate of Science degree, two earned an Associate of Applied degree in Respiratory Therapy and one was trained within the hospital they worked before earning a degree outside of Respiratory Therapy. Table 1 identifies gender, ethnicity, and number of years of experience.

Table 1. Participant Demographics

Name	Gender	Ethnicity	Experience (Years)	Educational Level
Carson	Male	White	Over 30	Bachelor of Science
Ray	Male	African American	26	Bachelor of Science
Megan	Female	White	10	Bachelor of Science
Mary	Female	White	Over 30	Institution Trained
John	Male	White	10	Bachelor of Science
Connie	Female	White	27	Associate of Science
Toni	Male	White	25	Bachelor of Science
Jesus	Male	Hispanic	20	Bachelor of Science
Laura	Female	White	28	Bachelor of Science

Name	Gender	Ethnicity	Experience (Years)	Educational Level
Jimmy	Male	White	20	Associate of Science
Karen	Female	African American	4	Bachelor of Science
Willis	Male	White	12	Associate of Science
Bonnie	Female	African American	6	Associate of Science
Stacey	Female	African American	5	Bachelor of Science
Aaron	Male	African American	23	Associate of Science

Carson

Carson graduated from a Bachelor of Science degree program at a medical school and came back to work in his hometown. He has been at the institution for most of his professional career. Carson came into respiratory therapy when it was expected for a therapist to work in all areas of the hospital. Working the night shift, Carson was expected to be competent in the adult, pediatric, and neonatal intensive care units. Therapists could be assigned to any of the areas and were expected to be the managers of care. He earned his Registry credentials (RRT) early in his career, no licensing board existed and the term RCP was not existent.

Carson's ethical dilemma began when a vice president of the institution he was working in was admitted to the Intensive Care Unit (ICU). The vice president had been involved in a motor vehicular accident and was admitted for the trauma involved with the accident. After Carson made rounds, the vice president called Carson over to the bed and asked several questions. It became clear that the vice president wanted preferential treatment over the other patients in the ICU. Carson was a new graduate, but did realize that patients were to be treated equally. Carson's medical director came around that night and reinforced that the vice president

was not to be treated any different than any other patient. The dilemma was that Carson knew that the vice president had the power to make his life miserable, but he also knew that preferential treatment went against medical practice.

Carson believes that past experiences helped him make decisions today that were ethical in nature. In the first few years of work, Carson admitted that he concentrated on caring for patients and making sure that he did nothing wrong. Ethics were not as important as not harming the patient. He said that in his first thoughts in this ethical decision making was complicated and that he was “little bit unsure of myself.” In the later years as experiences grew, he recognized that when a similar situation arose that he “just remembered precisely what my Medical Director had said.”

Ray

Ray also graduated from Bachelor of Science degree program at a medical school and came back to work near his hometown. Ray has been an RCP for 26 years. He is well liked by his coworkers and has a vast knowledge of medicine. His expertise spans the adult, pediatric, and neonatal intensive care units. One of his responsibilities is to educate physicians, nurses, therapists, and other health care professionals. He is active in his church and volunteers for social community organizations.

Ray recognizes that ethical decision making is complex. Describing a situation of a 65 year old stroke victim where removal of life support equipment was discussed, he stated, “the quality of life is a big issue.” Ray knew that even though the physician had given the order to remove life support, the family was not sure if this was the right thing to do. Family members were not sure they should discontinue ventilator support and the medial staff knew that all that could be done was being done and the outcome was hopeless. Ray was going to be the one to

remove the life support and this may not be what everyone in the family wanted. The dilemma as described by Ray was, “I know at times when your loved one's there and you’ve done all you can do and you still just can't let go, but at the same time you, I think it's important to respect what their [the family's] wishes are.”

Megan

Megan has been an RCP for ten years. She graduated from a Medical College with Bachelor of Science in Respiratory Therapy. She has only worked in the institution where she works now. Due to her excellent patient care and leadership qualities, Megan has recently moved into management. Her expertise transcends the gamut of Respiratory Therapy.

Megan’s ethical dilemma involved whether to resuscitate a premature infant. She describes a high risk delivery and the decisions that must be made very quickly. She states,

I think the ethical dilemma is for us is we know that sometimes we're doing something that's really just going to prolong the inevitable course which is the death of that infant.

But because of the parent's wishes and even no matter how minute the possibility that the child may make, we often you know, do things that taking the parent's out of the equation we should not normally do.

Megan reiterates what Ray said. She believes that the ethical decision making process is complex and that it helps when the RCP has experiences to rely upon. She talks when she was a new RCP and says, “You're not as confident, you're not as comfortable and it's more emotional for you when you're new in that situation.” Even though like Ray she pulls from experiences, her experiences are personal. Her child was born premature and had medical issues and she said, “it gives me a different perspective because I can feel it and sense it from the parent’s point of view.”

Mary

Mary has been a Respiratory Therapist for over 30 years and learned her skills in a job based program at the institution where she works. She works in the adult areas including the intensive care units. She is active in her professional organizations and served in many capacities in these professional organizations. I met Mary at a professional education meeting and we sat talking about the issues facing RCPs at that time. She believes that RCPs should be active in state and national affairs. Mary is compassionate about her profession and compassionate about the patients she treats.

Mary's ethical dilemma came as she was working in the laboratory. A blood sample came in and a low potassium level was analyzed. The physician had not written an order for a potassium level, but the blood analyzer reported many values. The dilemma that Mary had to resolve was whether to report the low potassium that was not ordered. Mary knew that low potassium levels can cause lethal cardiac arrhythmias. Sophisticated lab equipment has the ability to analyze more than the physician orders. Her ethical dilemma was to report a lab value that the physician had not ordered as policy dictated or to go against policy and report the value. Mary recalls, "So the first thing I did actually was to check with this other young person who works in the lab more frequently than I and say what do we usually do in this circumstance? And she said, we don't do anything with that. If it wasn't ordered we don't do anything. And it just didn't feel, it just didn't, I did not like the answer. I didn't like the answer; it didn't feel right in my gut." Mary searched the medical record and found where another critical lab value was reported a few hours earlier. She did admit that if the value had not been reported, she would have broken protocol and reported the value to the physician.

John

John graduated from a medical college with Bachelor of Science in Respiratory Therapy. He graduated approximately ten years ago. John was one of the most gifted RCPs that I have had the privilege to meet. Even upon graduation, I noticed his professional demeanor, his extraordinary knowledge, and his compassion toward his patients. His colleagues have a high regard for him. Religious beliefs guide John in the way he conducts himself around patients and patients' families.

John's ethical dilemma involved a patient with chronic health issues including breathing problems. The family needed to make a decision whether to allow a tracheotomy procedure to be performed or remove their loved one from mechanical ventilation. The family recognized John from the emergency room where he took care of their loved one in the initial stages of the hospital stay. They had developed a relationship with him and wanted his opinion on the matter. John recalled,

They were trying to make the decision about what to do with this lady. One of the options they had was to trache her or just take her off the ventilator. I explained to them what a trache is, and what we would do with that, and some of the pros and cons of that. And then also I brought to their attention that if that was not her wishes to have all that done then they may need to uphold her wishes and just remove care from her. So in that situation, I could have tried to sway that family one way or the other, but I guess I made an ethical decision in my mind just to present the facts on either side from my viewpoint as a therapist with her.

John's decision was to be as unbiased as possible so the family could make a decision that they could live with.

Connie

Connie attended a large university in a different state than where she began work. She graduated with an Associate of Science degree in Respiratory Therapy and began working in a large medical center with a progressive Respiratory Therapy department. Connie is well liked by her colleagues and is considered to be an excellent Respiratory Therapist with the skills and knowledge to work in all of the areas of the hospital. Connie now works mostly with the pediatric and neonatal populations.

Connie described a situation where a near drowning victim came into the Pediatric Intensive Care Unit (PICU). A near drowning child was resuscitated in the PICU and was placed on a mechanical ventilator. As Connie describes, “we had done all these necessary scans, CT scans, brain flow and all of that. And the child ended up coding again and we went through the whole resuscitation process again, and the physician had asked is everyone comfortable with us stopping this resuscitation”. Connie was providing ventilation to the child with a manual resuscitator. Even though the physician orders the resuscitation effort stopped, the physician’s ethical values may have conflicted with Connie’s ethical values. Connie had to evaluate the situation because she knew that when she stopped manually ventilating the child, the child was going to die. Connie did believe that in this situation, the physician was correct in the assessment of the situation and could discontinue manual ventilation. Connie’s experience with a particular ethical decision is based on her relationship with her own children. Working in the Pediatric Intensive Care Unit she says hits home the most “because she relates the patient to her own children.” She says the ages of the children during her career are “the age of your own children or grandchildren”. When dealing with these young patients, she thinks about her children.

Toni

Toni graduated from a large university with a Bachelor of Science degree in Respiratory Therapy and worked in a large urban hospital. She earned a Bachelor of Science degree in Respiratory Therapy. Her experiences relate to the adult population in Intensive Care Units.

Toni had a patient with a debilitating muscular disease. The patient did not want to be intubated and placed on mechanical ventilation. The patient had completed a form that is required of patients known as advanced directives. This patient's advanced directives included no use of mechanical ventilation. The only family member lived out of state. Toni describes this patient's condition,

She had no family in the area. The physicians really wanted to intubate her. They felt that this situation was something that she would overcome and that she would probably go back to her baseline. They called her daughter in (another state) and we all sat in on that situation with the physicians and spoke to her daughter and actually kinda over ruled her wishes and went ahead and intubated her.

Toni admitted feeling uneasy about the decision because the patient was competent to make the decision for herself. She was the one that was going to perform the intubation and place the patient on the ventilator. As she thought about the situation and the disease process, she concluded that intubation and mechanical ventilation was the best avenue to take.

Jesus

Jesus graduated from a large medical college with a Bachelor of Science degree in Respiratory Therapy. He began working at the institution where he is after graduation. He began working in the Adult areas, but then requested to work solely in the pediatric and neonatal areas. Jesus has twenty years of experience and is highly regarded by his colleagues.

Jesus' ethical dilemma involved a newborn. The infant was premature and had many health issues that required life sustaining measures. The infant was placed on a mechanical ventilator that could breathe up to 2000 times per minute. The infant's heart rate was slipping in the eighties and nineties which is detrimental for a newborn. Jesus realized that everything was being done, but to no avail. Regardless of the decision of the family and physicians, Jesus was struggling with continuing with futile attempts at life. He looks at ethical dilemmas in the context with his personal life. He states, "I would imagine if it was me, what would I want if it was my child, if it was my family member what I would want, or what my family member would want." He makes conscious efforts to do what he thinks is the best for the patient and the family.

Laura

Laura graduated from a medical college with a Bachelor of Science degree in Respiratory Therapy. After graduating, she came to a large medical center where she has worked for twenty-eight years. In the early years, she worked in all areas of the hospital, but over the past fifteen years works exclusively with pediatric and neonatal patients.

Laura recounts a dilemma involving a young child with a terminal illness. The decision was made to terminally wean a child that had an incurable muscular disease. Laura had interacted with the child and the family. She recounted the entire process in detail as she describes her decision,

I don't know how to word it. I was taking care of this patient for a few days and I had seen the whole interaction with the family and, it's probably one of the first times I had seen a child that interacted. That we were going to terminate the care of and so I probably prayed about and it's easy not to say anything. We talk to each other (healthcare professionals) in there and tell them what's happening on our part of the medicine and we

talk to the family. And so all of these things help you process this in your mind and it's what is going on. And so I thought about it and, I thought about my experience in the past, in the years that have passed with other children that have died that may have been declared brain dead or may have just been so far gone in their illness that they just weren't going to recover. And so I thought about all those things and I thought about that child how that child had been prior to this time here in the hospital because the child never had been a normal child. And so I just took all those facts and looked at them and I also took my beliefs, my own religious beliefs that we can't always play God into fact. And that's how I made the decision that I felt like I couldn't live with that if I was the one to do it. So I took all that in and weighed it up and I said what I had to say to the doctors and nurses away from the bedside and I let it go at that.

Tears came to her eyes as she described the events.

Jimmy

Jimmy graduated from an institution outside the state in which he practices. He earned an Associate degree in Respiratory Therapy and after working for twenty years is going back to school to earn a Bachelor of Science degree. Jimmy is motivated and wants to be the best caregiver for his patients.

Jimmy seems to struggle with one of the ethical dilemmas he faced as a young practitioner. He was involved in a delivery with a nurse and they had to make a very difficult decision. As Jimmy reflects,

it was a very difficult decision to have to make. To this day [I] question did I do the right thing or not, because part of me realized during the decision making process that the chances of that patient not surviving was probably less than ten per cent. But you have to

look at a baby who is moving and is attempting to breathe and (the practitioner) not to do anything. I felt [it] would be a harder decision for me to not do anything in that situation than it would be to do something.

It is difficult as a young practitioner to make immediate decisions with irreversible consequences.

Karen

Karen was the least experienced RCP that I interviewed. She graduated from a university with a Bachelor of Science degree and began work at the institution four years ago. After speaking with her, I recognized that she had an excellent grasp of respiratory physiology, diagnosis, and treatment.

Karen described an incident with a physician in his residency. She was caring for a patient with Acute Respiratory Distress Syndrome (ARDS), a disease that adversely affects breathing. The patient was receiving mechanical ventilation and the physician wanted to increase the respiratory rate to a dangerous level. Karen knew that the change was not appropriate so she had to disregard the physician's orders and made changes "that made the situation a little better for the patient's safety". Karen made the changes then used the situation to teach the physician a safer way of improving the patient's breathing.

Willis

Willis graduated from a community college with an Associate of Science degree in Respiratory Therapy. After he graduated, Willis went to work for a large urban hospital in the southeast. He has worked in the adult population for the twelve years since he graduated.

Willis described an event where a woman's heart had stopped and Advanced Cardiac Life Support (ACLS) was delivered for thirty minutes without any response. ACLS was stopped

and then the patient's eye began twitching. A lethal heart rate ensued, but was not treated by order of the physician. Willis had to decide if the physician's ethical value differed from his ethical value. Willis knew as soon as he stopped manually ventilating the patient, the patient's heart rate would return to zero. If the physician's order was viewed as wrong, the RCP would be complicit in the actions that followed. The American Association of Respiratory Care (AARC) state of Ethics and Professional Conduct states that RCPs should "respect and protect legal and personal rights of the patients they care for." (See Appendix A)

Bonnie

Bonnie graduated from a technical college where she earned an Associate of Science degree in Respiratory therapy. After college, Bonnie began working at a large urban hospital in the Southeastern United States. She works mostly in the adult intensive care units. Her supervisor has a great deal of respect for the care she gives her patients.

Bonnie's dilemma occurred in the Adult Intensive Care Unit. She was taking care of a friend's father that was critically ill. One day her friend's father took a turn for the worse and was rushed to the operating room. During this hectic time of preparing for her patient's transport, her friend wanted information on what was going on. Bonnie said her friendship was very important, but her patient's care was her top priority. She had to ignore her friend so she could hurriedly prepare the patient for transport. Her dilemma was whether to take care of her friend or take care of her father. Bonnie did not know if her friend's father had time for her to delay in the care of him.

Stacey

Stacey graduated from a four year college with a Bachelor of Science degree in Respiratory Therapy. Upon graduation, she began to work in a large urban hospital. She worked

with pediatric and adult patients in the critical care areas. She performed so well, she was offered a position in management after her third year.

Stacey's dilemma involved a homeless man that had developed end-stage cirrhosis. The cirrhosis caused him to develop respiratory failure and he was placed on mechanical ventilation. When it was evident that the patient was not going to recover, attempts were made to find his family to discuss terminating ventilation. No family was found. Stacey's dilemma was that she was removing the ventilator, and she felt bad that this patient was not going to have family around for his last moments. Even though she recognized that discontinuing mechanical ventilation was the best option, she had a hard time thinking that this man was going to die alone. Maybe a little more time would allow authorities to find this man's family.

Aaron

Aaron graduated from a nontraditional institution where he earned an Associate of Applied Science degree in Respiratory Therapy. Aaron is well respected by his peers for his knowledge and level headedness. After graduation, Aaron began work at the institution where he has spent 23 years.

Aaron's ethical dilemma began when the physicians were trying to determine brain death in a child. During this procedure, the physician, nurses, and Aaron were present. Aaron removed the patient from the mechanical ventilator for eight to twelve minutes to determine if the patient would breathe spontaneously. One in the group thought the patient did take a breath, but no one else saw the patient's effort. The patient was medically declared brain dead, and was removed from the mechanical ventilator. Aaron's dilemma was whether to remove mechanical ventilation on what someone thought they may have seen.

Results

Three sets of findings emerged from the three questions that guided the study. Table 2 summarizes the findings that reflect the learning process to make a decision about an ethical dilemma involving Respiratory Care.

Table 2. Learning to Make Ethical Decisions in Respiratory Care

I. Ethical Dilemmas Faced by Respiratory Care practitioners and Where They Occurred
A. Terminal Weaning / Removing from Mechanical Ventilation
B. Resuscitating or Not Resuscitating
II. Steps and Influences in Ethical Decision Making
A. Steps in Ethical Decision Making
B. Influential Factors in Ethical Decision Making
1. Quality of Life Beliefs
2. Personal Experiences
3. Religious Beliefs
4. Ethic Committees
III. Learning Processes of the Respiratory Care Practitioner
A. Formal Learning
B. Informal Learning

Ethical Dilemmas Faced by Respiratory Care Practitioners and Where They Occurred

The participants described the circumstances that were involved in the ethical dilemma. The conditions included making life and death decisions within the Intensive Care Units. All participants identified ethical dilemmas where life or death of their patients was evident. Life and

death situations occur when a decision is based upon sound medical judgment that the patient may not benefit from continuing or additional medical intervention. In many institutions, it is the Respiratory Care Practitioner (RCP) that is responsible for maintaining an open airway and ventilating the patient. The RCP is usually the health care provider that discontinues ventilation that results in the patient dying. The most common ways to discontinue ventilation is to terminally wean patients from ventilation and removing patients from ventilation.

Terminal Weaning / Removing from Mechanical Ventilation

Two ways to discontinue mechanical ventilation is to terminally wean the patient or to remove mechanical ventilation suddenly. Terminal weaning includes systematically reducing the respiratory rate on the mechanical ventilator over a set period of time until the respiratory rate reaches zero. Regardless of the patient's response, the rate decrease continues until no mechanical ventilation is provided. Another approach is to remove mechanical ventilation support completely in a very short period of time and remove the artificial airway. Regardless of the patient's response, mechanical ventilation is not reinstituted.

For some RCPs the situation involved terminally weaning a patient from mechanical ventilation. The terminal wean involves physicians determining whether it would benefit a patient by keeping the patient alive with artificial means. Many times physicians ask input from the healthcare team. The RCP delivers an opinion based upon medical inevitability, family input, patient input, and personal beliefs. On a few occasions the healthcare team is not consulted and the physician makes the decision. Once a decision is made to terminate mechanical ventilation, it is the RCP's decision as to whether to follow the physician's orders or object to the order and not follow the order as given. The RCP must determine if the physician is right in their judgment or

whether the values of the physician conflicts with the values of the RCP. This presents itself as an ethical dilemma for the RCP. The patient will die when mechanical ventilation is terminated.

Ray's patient had a stroke and there was discussion as to whether mechanical ventilation should be removed. The physician believed that mechanical ventilation should not be continued, but the family wanted to continue ventilation, Ray did not find himself at odds with the physician, but at odds with the family wishes. He explains,

And being a clinician, a therapist at that time, I was placed in a situation where the family wanted to continue with everything in the life support of this patient and the physician based on the medical issues at hand, the medical case of the patient was withdrawing care of life support. And my issue was that I truly felt that everything had been done with this patient from the medical standpoint, but at the same time I could see where the family was at that point in time because it was not a older person, a middle aged person but wasn't ready to totally let go of their loved one.

Ray had worked with the Ethics Committee at the hospital before and understood the importance of family wishes. He was torn between the inevitability of the patient's demise without any quality of life and the spouse's love of her husband.

John had a similar experience removing mechanical ventilation from a patient. The family, however, needed direction in to how to proceed in a way that was the most benefit for their family member. The patient was obese, placed on mechanical ventilation and a decision needed to be made as to whether to decelerate care and remove mechanical ventilation and allow the patient to die. The family member's son approached John. According to John, the son had the power to make the decision for the patient. The son asked John for his opinion and asked him

about the options for his parent. John explained the different procedures that would be performed to keep his parent alive. John talking to the son said,

And then also I brought to their attention that if that was not her wishes to have all that done then they may need (to) uphold her wishes and just remove care from her. So in that situation you know, I could have tried to sway that family one way or the other, but I guess kinda I made an ethical decision in my mind just to present the facts on either side from my viewpoint as a therapist with her. This patient was completely awake and alert, coherent; no type of neurologic deficits, so she would've known everything that was going on to her. So I guess I kind of had to make a decision that would try to offer some type of slant to that family to do one type of care versus the other with her. But I tried to just present it in a neutral way.

John thought the best approach was to be as unbiased as possible so the family could make a decision that they could live with for someone they loved.

Ray's and John's dilemmas occurred in Adult Intensive Care Units. The intensive care units have patients with the most serious illnesses, injuries, or anticipated emergent conditions. The patients in this area are closely monitored and receive specialized care. The patient to healthcare provider ratio is very small. Adult Intensive Care Units treat patients over the age of eighteen and can be specific to disease entity or illness. Patients with heart or circulatory problems may be admitted into a Cardiovascular Intensive Care Unit (CVICU). Patients who have had extensive surgery and need close monitoring are found in a Surgical Intensive Care Unit (SICU). Patients with general, serious health issues enter the Medical Intensive Care Unit (MICU). The Neurological Intensive Care Unit (NICU) admits patients with neurological problems such as stroke or head injury.

Ray's dilemma with a stroke patient where mechanical ventilation was being removed describes the area as the Neurological Intensive Care Unit (NICU). His patient, "suffered a stroke and the initial stroke wasn't that bad, but apparently had another stroke afterwards that really left him comatose." Like Ray, John and Jesus describe their patients being in the NICU.

John also talks about removing mechanical ventilation of a patient in the NICU. He describes the situation where he cared for a patient that had Pickwickian Syndrome [a chronic breathing disorder that affects patients more at sleep than when they are awake]. Pickwickian Syndrome also leads to other life-threatening medical issues such as heart failure. John recalls, "she was quite obese and had had been intubated for about a week. [She] was extubated and then ended up getting reintubated within two days because her CO₂ kept going up. She was just hypercapnic [increase in carbon dioxide levels]. Here I am coming back to work with this lady and the family is discussing changes on her code status to a status 3 then possible a status 4." A status 4 would be "basically removal of all that and just providing care and comfort to the patient."

Both Ray and John talk about the patient and what the patient was like before their circumstances led to removal of life support. Their patients had a quality of life before the injuries caused them to be completely dependent on others for their most basic needs, even breathing. Both RCPs looked to the family for information and in some little way guidance into a decision that cannot be reversed. Ray wanted the family to take into consideration the patient's wishes to discontinue care, but tried to present the various scenarios without bias. He stated,

I think one of the strongest things that that would influence me in trying to talk with this particular family was that this patient was like I said, neurologically intact. She was able to follow commands, nod her head; she seemed to be alert at times. So this is not a patient

that would never know what quality of life could be. So I was thinking I would like this family to make a decision that would uphold her wishes that she had expressed to them before she got so ill. So I just wanted to present that to them, their options so that they could try to take her wishes into consideration.

Ray recognized that more than one right answer was involved in this dilemma. Medical practice would allow a competent patient to make the decision in this case the patient wanted to remove life support. On the other hand do we as health care professionals ignore the wishes of the family that loves the patient?

Other participants also talked about their dilemma occurring in intensive care. Stacey's patient was terminally ill and she was concerned about removing mechanical ventilation when the patient had no family support. Her patient was treated in the Medical Intensive Care Unit.

Carson describes a dilemma when a vice president of the institution was admitted after being in a motor vehicular accident (MVA). The vice president summoned Carson to his Surgical Intensive Care room and asked the RCP if he knew who the vice president was. Carson said he was aware of the vice president's position. Carson was a young therapist at the time and had been told at some point that patients were to be treated equally. He also knew that this vice president was important to the organization because he had seen the Chief Executive Officer visit the patient. Carson could have easily ignored what he had learned about patients being treated equally by practitioners. He was grateful of a Medical Director that made it a point to come into the ICU at night and tell Carson that the vice president was not to be given any different care than any other patient in the ICU. According to Carson, the medical Director said, "not to treat the vice president any differently than I would treat any other patients in the Intensive Care Unit. That it was my job to treat every patient to the best of my ability and give no special treatment to

anyone regardless of position that they may have held in the institution.” Carson was caught between doing what the vice president wanted or what the medical director wanted him to do.

In the post interview follow-up, Carson revealed that the patient was not doing what the RCP or nurses asked of him. He was making all the health care givers life miserable. After the patient was discharged from the Intensive Care Unit and admitted to the floor, Carson was summoned to the patient’s room. The patient had been having serious breathing problems and the physician wanted the patient to be intubated. Carson intubated the patient nasally. The patient was very scared because he could not breathe adequately. His lungs were filling with fluid from complications of the trauma received in the MVA. Carson revealed that the vice president’s attitude changed immediately and treated the health care team afterwards with the respect they deserved.

Laura seemed to have the most conflicted involvement of terminating mechanical ventilation involving a child. She described a child that had a muscular defect where the child’s muscles were deteriorating. The child was not going to improve and would deteriorate. The muscle wasting had already affected her diaphragm, and she was placed on a mechanical ventilator to support her breathing. The child could respond to mother and father and to the healthcare team. The parents and physicians decided that they would provide care and comfort to the child and made the decision to remove mechanical ventilation. I could tell that Megan was truly torn about this decision. Laura’s voice changed as she described the situation and tears came to her eyes.

Laura described the positive aspects of caring for this child such as painting her fingernails and the nurses giving her the food that the child really liked. Laura described that she thought “that patient had more to offer than what the doctors thought. I thought maybe she was a

little bit better than what the doctors thought. And it wasn't time to maybe to stop care." Laura knew that the disease process not only affected the skeletal muscle, but all the muscles including the heart. She knew it was not going to be "a good outcome". At the post interview follow up, Laura told me what I already knew. People do not think that the healthcare team becomes attached to patients. They try to teach us in school not to get emotionally involved, but Laura knew that regardless of what is taught, healthcare team members do get attached. She does admit that this child was different in some way. She could interact with you and most children "most of the time the child doesn't smile at you or look at you".

Laura's dilemma occurred in the Pediatric Intensive Care Unit. Pediatric Intensive Care Units (PICU) treat severely ill or injured patients from one month to eighteen years of age. In most hospitals, the PICU treats all illnesses and sicknesses in one area; most do not have specialty areas. Family members are encouraged to stay in the patient's room while they are being cared for by the healthcare team.

Laura's patient was being treated in the PICU. The PICU staff allows patient's families to stay with the patient and interact. RCPs notice the interaction and that makes it hard to discontinue mechanical ventilation as Laura was asked to do. Laura describes the hours leading up to the dilemma,

the family was allowed to have their time. I mean this is really weird, but they were able to do last minute things with this little girl. They painted her fingernails, they were able to give her food that she liked, and they did all of these kinda things for her and at the end of the day, they were going to withdraw all of the other support from her. So I sort of separated myself from that. I didn't really go into the room [when the parent – child interaction took place] and I didn't like the whole situation. So I was there in the unit, but

I wasn't the one to turn the ventilator off and I separated myself from what was happening.

Laura made the decision that even though the physician's order was to withdraw mechanical ventilation, she could not remove the mechanical support.

Like Laura, Connie and Aaron described experiences in the PICU. Connie works with newborns and pediatric patients. Connie recognizes that, in an intensive care unit and emergency room setting, devastating events happen. Speaking of a near drowning child, she states, "the quality of life that may pursue after we have coded somebody for too long; we have gone on and on and on and we bring them back and you have a person who doesn't have really any quality of life. So I think in just experience, (inaudible), just seeing different things happen that you know, that's how I can make that kind of decision." In all of the adult, pediatric, and neonatal areas, quality of life is an issue for these RCPs.

In order to have everyone involved, physicians will ask the people of the healthcare team their thoughts. Connie works in such a place. Connie acknowledges that in the area where she works when a code of a child is not being successful that "some of the Intensivists [physicians specializing in critical care] will ask us if everybody is comfortable with stopping this." Even though the physician asks, this does not mean that everyone will agree. Connie agreed that if she had been uncomfortable with the decision, then she would speak out for the patient.

Aaron also was involved in a dilemma in the PICU. An apnea test was being performed to determine brain death. It was determined that the patient was brain dead and the ventilator was going to be removed. Aaron revealed that it was tough dealing with the consequences of removing a ventilator from a child. He said that he thought about his children and always came

back to what was the best for the child. He remembers a Pediatric Intensivist [a physician trained in critical care medicine] always telling him that there were worst things than death.

Resuscitating or Not Resuscitating

In emergency situations, decisions are made as to whether to resuscitate the patient or not to resuscitate. Resuscitation includes giving medications, fluids, and delivering breaths to a patient. The RCP may administer breaths manually or mechanically. Depending on the circumstances, decisions may be made not to initiate any type of life saving measures or to terminate life saving measures.

Decisions that RCPs must make include the dilemma of resuscitating a patient or not resuscitating them. Sometimes these dilemmas present in labor and delivery and decisions are made on whether to resuscitate a newborn. Megan describes,

in the institution where I work mothers come in preterm labor. And they're only twenty-two, twenty-three, twenty-four weeks pregnant. And when the babies are born under a certain weight or not mature enough, you have to make decisions on what to do with them when they're born. And there are certain factors that would lead you to believe that the baby would not survive no matter what you do. But there are a lot of factors that come into play as to what we are legally and ethically responsible to do.

There are times when the mother has prenatal care and the healthcare team can anticipate resuscitative needs. Megan describes that when a mother has prenatal care, an ultrasound will be performed and the baby's gestational age can be determined. If the mother has had prenatal care, then the physician and neonatologist may have the opportunity to talk to the parents before the delivery takes place. Megan acknowledges that "sometimes the parents may decide we don't want anything done." However, there are times when decisions must be made on the spot.

Jimmy remembers a situation twenty years earlier in great detail. He remembers, I was a new graduate with a new graduate nurse that attended a delivery. The infant ended up being about twenty-two weeks gestation. There was no doctor, no practitioner that was in house and the two of us had to make the decision of do we attempt to resuscitative measures or not?”

Even for an expert practitioner, this is a tremendously difficult dilemma to resolve. These two recent graduates were placed in a position to make a very difficult decision. These decisions stay with practitioners. Jimmy admitted that this situation “stuck with me throughout my career.” Some institutions have physicians that not only care for the patients, but also care for the people taking care of the patients.

The dilemmas described by Megan and Jimmy occurred in the Neonatal Intensive Care Nursery or Labor and Delivery. The Neonatal Intensive Care Unit (NNICU) treats newborns that have serious illnesses or trauma from the birthing process. Monitoring and low healthcare worker to patient ratios exist in this unit. An extension of this unit is Labor and Delivery. In many hospitals, RCPs attend all high risk deliveries. If the newborns are seriously ill or injured, they will be directly admitted to the NNICU.

Jesus also describes a patient in the NNICU. He describes the patient as “an extreme premature baby, maybe born at 22 weeks and had severe IVH, intraventricular hemorrhaging. We were having trouble getting a blood pressure and maxed out on dopamine [a medication to increase blood pressure] and epi [epinephrine].” The infant was being ventilated with an oscillator. The heart rate was decreasing and the patient was already diagnosed with an intraventricular hemorrhage. Describing the situation, Jesus further explained,

And this is on the maximum ventilation support that we have. The oscillator were high, high settings on the conventional ventilation. And of course the baby's heart rate (was) slowly dipping down or maintaining like in the 80's to 90's with no improvement regardless of what we do. So the physician talks to the parents and then basically we leave the decision to the parents, of what to do next.

The family decided to remove the mechanical ventilator and take off all support. Jesus knew that once he removed the ventilator the baby was going to die. If he could not remove mechanical ventilation, he would have to summon his supervisor. He recalls that he did not have a problem with the decision. He states,

I know it was the best thing to do; it was the best thing for the patient, for the family members. I've seen some folks that don't like to take off the patients [remove mechanical ventilation] and they ask somebody else to it, but for me I believe it was the best choice to do, I mean the best thing for the patient rather to continue to subjecting [him] to artificially supporting their life.

Dealing with newborns is tough, because most parents are looking toward the future with their baby. Technology has outpaced the field of bioethics. Ten years ago, a 22 week gestational age newborn would not even have been considered for resuscitation. Now with medications and mechanical ventilators that can breathe three thousand breaths per minute, younger and younger newborns are given a chance. The healthcare team made a decision to provide mechanical ventilation to a premature infant where survival approached zero. After a few days, the infant's condition deteriorated. The team recognized that further attempts to resuscitate would not be medically reasonable. Jesus knew he would be the one that removed mechanical ventilation, and he had to determine if the team has gone this far, why should we not go a little further?

Labor and Delivery is a unique setting. Many newborns need very little assistance from the healthcare team. Even those deliveries considered to be high risk deliveries, the newborn needs very little assistance. Then there are those deliveries with complications. It is an environment where decisions must be made in a very short time. Megan describes Labor and Delivery and the action that takes place there. She explains the sequence of events, “we are in the delivery room when the baby, when the OBGYN takes the baby out of the mother and basically hands the baby to the respiratory therapist for resuscitation. A baby that's born very premature is not able to last very long on their own.” In every intensive care unit the unexpected happens and decisions are made quickly.

There are places and situations where ethical dilemmas are posed for RCPs that require them to make decisions. In the Intensive Care Units, life and death situations occur regularly. The RCP must make the decision to remove life support or stop resuscitation. Before life support is terminated, the RCP must determine if it is the right choice for them to make, even when confronted with the order to do so. The next section shows how they learned to make those decisions.

Not all resuscitation efforts are related to newborns. Ethical decisions on whether to resuscitate adults are also common. Willis describes a patient that was moved from an intensive care unit to a unit with telemetry. The patient's rhythm was monitored, but when the nurse went into the room, the patient had no pulse. This situation is called pulseless electrical activity (PEA). Once the nurse determined pulselessness, a code was called. Willis was a part of the code team. Willis intubated and began manually ventilating the patient. Willis stated,

we had a code and the patient on the monitor was on a tele room [telemetry room where heart rhythms are monitored] and the monitor never showed v-tach or asystole [life

threatening arrhythmias] or anything. She apparently went from a perfusing rhythm to straight to PEA and she was found she was coding or was unresponsive and no pulse and not breathing when they walked in the room to do vitals on her, or to check on her.

The team went through the algorithm for PEA and after several pushes of epinephrine the patient did not respond. The patient developed a shockable rhythm, but the physician decided not to continue on with the code. The patient's heart may have slightly responded to the multiple doses of epinephrine, but it was not a perfusing rhythm. Willis recalls,

We ran the code for thirty minutes or more, did multiple rounds of drugs, PEA through the whole thing. We'd given everything we could think of and the doctor called it. At the time she called it, we unhooked everything, unhooked the bag and everybody was pulling their gloves off. And the woman who had not made any movements through the whole code, then started making eye twitching and stuff like this, and we thought it was just nerves and turned around and looked on the monitor and she was in v-fib or Torsades [an arrhythmia that can be defibrillated]. The decision was made by the physician not to pursue the code for the fact that we had been working for thirty minutes with nothing and we knew that she, we did not know how long she had been down because she was in PEA from the get go so we called up to the monitor techs and asked them.

Again, Willis knew that when he stopped manually ventilating, the patient's heart rhythm would develop into systole and the patient would have no chance for survival. Willis had to decide if the physician's ethics conflicted with his. He had to decide if he were willing to stop ventilating the patient.

Steps and Influences in Ethical Decision Making

Steps in Ethical Decision Making

Processes relate to the steps that RCPs traverse to make the ethical decision in the dilemmas they described. The process is a procedure for making the ethical decision.

When asked the process they went through to make an ethical decision, the participants described a process that included identifying that an ethical dilemma existed, they sought a solution by various methods, they made the decision, and they reflected on their practice as it applied to the ethical decisions. Ray knew he had a choice of whether to terminally wean his patient or seek his supervisor if he was unable. He sought solutions from “the standpoint of the medical team and everything that they did from the test standpoint, from the neurological standpoint, the consults from the neuro physicians and so forth. So I think from a medical standpoint they were right on point.”

Ray also sought input from family and the patient’s wishes and was able to make a determination that he could terminally wean this patient. He acknowledged, “it was appropriate in this case from a medical standpoint to do a terminal wean.” Ray implied that he has extensive experiences as they relate to terminal weaning. He states, “I have been on the ethics committee for fifteen years and going to various lectures and hearing various cases over the years has helped. Also just going to different lectures concerning end of life scenarios and end of life decisions helped, in this situation. I think it helped a lot.” Mary also described a process like Ray, but in very different terms.

Mary had a critical blood value on a patient. In her institution, the lab values ordered by the physician were the only ones reported. The machine that analyzes the lab values actually gives a broad spectrum of values. One of the values not ordered was a critical value for a patient.

She quickly identified this as an ethical dilemma and needed to make a decision as to whether to report it or not. Then she proceeded to seek information to determine a solution. Mary recalls, “So the first thing I did actually was to check with this other young person who works in the lab more frequently than I and say what do we usually do in this circumstance? And she said, we don't do anything with that. If it wasn't ordered we don't do anything. And it just didn't feel, it just didn't, I did not like the answer. I didn't like the answer; it didn't feel right in my gut.”

The next step that Mary took was that she reviewed the patient's record to determine what action she was to take. She noticed in the patient's record that this test had been run a few hours earlier and the critical value was called to the physician. Upon further questioning, I asked, what would you have done if the critical lab value had not been acted upon? She said, “I would have called in, yea, I had already decided I was going to call them.” Mary also implied that she reflected on this ethical decision. She states,

It's the right thing to do. It is the right and ethical thing to do. It could be clinically important, and not rocket science, this is a little ole lab value that I know about and if I'm going to let a little thing like this, I mean, if I'm going to just ignore a little thing like this, then, then what kind of big things would I ignore? I mean that just seems really frightening to think that I couldn't live with myself ignoring, I just couldn't live with myself walking away from something. It would gnaw at me.

Laura also described the ethical decision making process like the others, but added that as she matured she was able to express her concerns. Laura admits that in her early career, she did not know that she had a choice when an ethical dilemma presented itself. But as she matured she realized she did have a choice. Speaking about ethical dilemmas Laura states,

I actually had a choice, but as I have aged and matured into it and I realized that I do have a choice and I can make that known. I can make my beliefs known I and they're respected and I'm ok with that and they're ok with my opinion. We both understand that we have a side to it. I don't think I could have done it earlier. I don't think I could have done it when I first graduated. I think I would've gone with the flow and not said anything and maybe took it home with me.

Laura is very open with the decisions that are made and realizes that when she disagrees with the decisions, then an alternative path exists.

Mary had a very difficult decision to make, but many ethical dilemmas seem to tug at the practitioners' conscience. Most described the importance of reflecting on other cases and then reflecting on the cases that they were involved in. In general, most of the participants identified a process of ethical decision making consisting of identifying the problem, generating a course of action, considering potential consequences in all of the courses of action, evaluating the selected course of action, and then reflecting on their decision. Even though these RCPs did not follow a specific, prescriptive model, the RCPs' decision making process did have commonalities with models described in the literature.

Influential Factors in Ethical Decision Making

Influences are those people or factors that have an impact on the RCP to make ethical decisions. These influences may have been colleagues, but could also include professional experiences, personal experiences, religious beliefs, or an Ethics Committee.

Quality of life beliefs. Quality of life is one of the most debated ethical principles in medicine today. The quality of life issue asserts that individuals do not want to receive care if it means that their activities of daily living are severely compromised. Many of the participants in

this study described quality of life issues. Ray kept mentioning quality of life as he was describing the ethical dilemma where he had to make a decision. He stated,

Let's say for this individual case for him to be on the ventilator for, I don't know how long, [the rest of] his life. That's not how they [the family] remember their father, their husband, and so forth, the grandfather, whatever. They remembered him prior to this, being active in their life, being very much involved, so quality is important. We each may live different years, but it's the quality, what have you done with those years. And I think that was the most important thing in this family's case is that this person even though he still had some more time, but the quality time. You can't measure that against now him just laying there lifeless and everything. As far as the quantity it's the quality the big issue.

It was evident that Ray believed in the quality of life as opposed to having a loved one lie lifeless in bed and wasting away.

It seems that Connie also believes like Ray in that her belief in the quality of life plays an important part in his decision making process. As Connie describes her reflecting about the near drowning patient, she states,

Well as far as reflecting, of course there always might be that thought in in in your mind, did we do that right thing? But then again as I have said before, when we see resuscitations that have gone on and on and on and we actually bring back a child and what we had brought back as far as yes we brought back a heartbeat, but then again we have no quality of life for that child. Sometimes and you know this, I think a quote that I have heard several physicians, namely the pediatric physicians, I have heard them say,

there are worst things than death. I think just in all the years experience that I've had and everything that I've seen, that that helped me make that decision.

Toni also reflects the thoughts of Ray and Connie. Describing those things that may have influenced her decision in her ethical dilemma, she says,

And again I have no problems asking questions. As far as you know, if you hear a physician say [removing mechanical ventilation] and to know in your heart yourself, you have done everything for this patient, there is a terminal illness here and they've lived up until this point, their lives from here on out will not be quality, that you know, [this] has to be enough.

Laura, Willis, and Stacey also discussed quality of life issues. I felt that each of them believed in quality of life over attempting everything humanly possible to keep a patient alive that has no hope of recovery.

Personal experiences outside of work. Personal experiences are those occurrences in life, outside of work, that reinforce the behavior that we should exhibit. When making ethical decisions, other circumstances may help RCPs make and justify the decision made.

The most common influence on the participants' ethical decision making was personal experiences. These experiences ranged from personal experiences with family members in the hospital to experiences from within the medical community itself. Megan describes her personal experiences with her child that heavily influences her ethical decision making, especially in the pediatric and neonatal units. Megan explains,

Well I've had a child that had a lot of medical issues and has been in the hospital, has been on a breathing machine and that does put a different aspect on it. Now he was not a premature child, he was an older child so when I work areas where I am working

pediatric intensive care, it gives me a different perspective because I can feel it and sense it from the parents point of view. Because I have had a child in in a grave situation, it may help me with the way that I talk to them or deal with them a little bit better than somebody that doesn't have that same understanding.

Others have talked about their own children and grandchildren as they are making these difficult decisions. When Connie talks about near drowning and the ethical decisions that may need to be made in that situation, she acknowledges that her children and grandchildren come into play. She states, “it's probably the ones that that hit home the most of course they are in the pediatric unit where you have got a child could be the age of your own children or grandchildren”. These ethical decisions are difficult on their own, but when a RCP begins to personalize the decision, it becomes incredibly difficult.

Mary identified another personal experience that helped her tremendously with her ethical decision making. Her parents were alcoholics and she attended ALANON. She describes her experience,

And after several years in ALANON, I finally did figure out that not all of our problems were mine, but the value in that was that it was really a large part of my spiritual development and a large part of the courage thing. A large part of being able to sort of set boundaries and determine when to speak up and when not to speak up and what was my problem and was not my problem and what was right and what was not right grew out of my experience in ALANON. It had a huge impact on my spiritual and moral development.

Religious beliefs. Religious beliefs for these participants are those teachings associated with spirituality and God. Common influences that participants said affected the ethical decision making process were their religious beliefs.

Carson talks about church influencing his ability to make good ethical decisions. He said, “I had some friends around seventeen or eighteen that introduced me to church. And I guess going to church that also influenced some of my decision making especially where ethics may be, may be involved.” Jimmy also mentioned his religious beliefs. He credits his religious beliefs as the most important influence on his ethical decision making. He states, “I would say number one would've been my religious beliefs.” Willis also says that he being a Christian helps him with ethical decisions.

Toni offered a slightly different slant. Toni says that, “Some people have very religious feelings about certain things, and it could be something along those lines but I don't feel the need to explain to the physician and they have never asked me why.” And she continues, “I'm not a overly religious person, but I pray a lot of times before I do that, I will say a little prayer and then I do it. And you know I try not to dwell on it (her spirituality).”

Ethics committee. Ethics committees have only been around since the early 1970s. They intervene in cases only when asked by participants of the healthcare team. The ethics committee will listen and offer advice, but cannot intervene unless an official request from a physician is initiated. Speaking of tools that would help, Ray talks about the ethics committee. He states, probably the only other thing in which occasion they do, they're not a decision making body, but the ethics committee involvement helps sometimes with these ethical dilemmas. Getting them involved early, again understanding that they can only make

recommendations and the final decision is up to the medical team and the family. But I think getting them involved early [is important for consensus of the decision].

Mary saw an additional benefit from the ethics committee. The ethics committee validated her concerns. She recalled,

And it's actually ended up with the decision that that was inadequate. I actually took the issue to the ethics committee which I serve on and to my surprise they actually were very supportive. We had quite an interesting discussion of the issue. And it was a very, very interesting and enriching discussion and they took it very seriously and it was rewarding. So that was that was really a helpful tool. So on that level, the organization actually, I should back up and say from that perspective the organization was very supportive.

This is another good reason to have an Ethics Committee involved in some ethical decisions so practitioners can learn from a group of experts. All of the other participants had other ideas ranging from policies that may enhance the ethical decision making process to taking the decisions out of the practitioners hands.

Learning Processes of the Respiratory Care Practitioner

The learning process entails the ways in which the RCP learned how to make a decision involving an ethical dilemma. Informal and formal educational endeavors play a factor in the way these decisions are made.

Formal Learning

In regards to RCPs, formal learning is usually associated with college classes or courses for credit toward a degree. Formal education plays an important part in developing the RCPs skills and knowledge. A few participants credited college with helping them develop these

ethical decision making skills, but others did not credit their formal education with much in the way of ethical decision making.

When asked how she learned the process, Karen said, “school and work”. Karen attributed her formal education for her decision making skills and her ability to helping physicians understand her point when it came to making changes that may influence patient outcome negatively. She stated,

I mean a part of it is just growing up and learning how to handle people appropriately, and I think it was really stressed in school that having a positive attitude and looking to other people for help. And also we learned in school that you're always going to be learning and you know, and you have to help other people learn as well.

Megan credited her formal education as the beginning process. She admits that other factors were involved, but in the beginning she was taught ethics in school. She said, “I mean it started in college with the ethics class. I think it's just one class. We were on quarter system way back when I went to school, so it was one quarter worth of an ethics class.”

RCPs learn formally and informally the way others make ethical decisions. The RCP takes these learning experiences and begins to apply it to their practice. This discussion of how participants learned to make decisions in ethical dilemmas suggests a process for making the decision.

Continuing Professional Education (CPE) is the education that a practitioner receives during his professional career. Houle (1980) writes, “the goal of all continuing professional education is the improvement of the ongoing performance of practitioners” (p. 91). CPE can take on many forms such as professional seminars, specialized classes in neonatal resuscitation or

cardiac life support. Sometimes RCPs take courses that offer a little guidance on ethics in medicine.

Some of the RCPs described taking classes such as Neonatal Resuscitation in the workplace. Megan credited a course in Neonatal Resuscitation Provider (NRP) as helping with ethical decision making. Being an instructor for NRP, Mary has a good grasp on the material she teaches to the nurses and therapists in the hospital where she works. One of the chapters in NRP is about ethical decision making. She does however recognize that not every scenario is covered in NRP. Mary explains, “having NRP guidelines and being certified in NRP, there's a section about ethics in the book. Although black and white is not always black and white we know in these situations especially in preterm deliveries, we know that it comes down to a joint decision.” Others also attributed some of their ethical decision making skills to NRP and similar courses.

Jesus also teaches NRP and has taken courses in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). He says that these courses have steered him in ethical decision making. Jesus describes the ethical aspect of NRP as

It's the last thing in NRP. If we've done everything possible that we could in neonatal resuscitation, would still (see) no improvement that you know, it's ok to stop. As long we have done everything possible, it's ok to terminate. I'm not sure ACLS and PALS teach, I think the PALS does touch on that on occasion. But those are the only really educational parts that I've ever seen. I've never gone through anything in school, well they may have touched it in school, but that's been so long ago, I can't remember exactly, but otherwise there's no real follow up education that I know except for some conferences that I've gone to have touched on it, they had a speaker talk about it, but nothing really formal per se, if that makes sense.

Informal Learning

Informal learning is unstructured learning. Marsick and Watkins (2001) state that informal learning is not “highly structured and control rests primarily in the hands of the learner” (p. 25). Examples of this type of learning for RCPs include learning from mentors and preceptors, experiential learning, bedside rounds, and case studies.

Learning occurs in the workplace or is somehow related to what is seen in the RCPs practice. Most of the participants described informal learning practices when dealing with ethical dilemmas.

Colleagues are peers that may offer advice during the practitioner’s career. Not only do colleagues offer advice, but through their actions, a practitioner may learn the way to perform procedures or how to deal with the situations that are faced in healthcare.

Carson said that he learned from colleagues. He stated that when situations arose, “my peers that worked within the hospital, especially those that had been there for a while were free flowing with information and especially with a relatively new individual they would take their time out to explain things as we would go along.” Whenever a situation arose and an ethical dilemma came up, his colleagues would explain the concept. They were an experienced group and were happy to help an inexperienced RCP.

Megan also credits colleagues for helping her with ethical decision making. When dealing with infants, it sometimes is especially difficult to remove emotion and rely on the facts. Megan recalls when she was an inexperienced therapist,

when you're new and start working in an area in a high stakes situation where you're making ethical decisions regularly, you're not as confident, you're not as comfortable.

And it's more emotional for you when you're new in that situation. At least it was for me.

I can't speak for every respiratory therapist, but as you gain experience and wisdom and taking part in these situations and in your training process you're with people who've been doing it for much longer. They're able to give you more examples, more experience, what to expect down the road, and then you become not dull to the situation or less emotional, but you become more factual and have more wisdom about the future. And so you learn through that experience of doing it over and over, making the decisions.

Laura spoke of others that helped her along her way. She developed the way she approached ethical decision making by learning from others and their experiences. As she talked about learning from others, Laura said,

I don't guess I realized at the time or it's not a conscious thing that I think that I've taken over the years, it's just something that I developed over the years, I guess. I'm sure I've developed it. I've seen others do it, and I would say that more so let's see I've been there over twenty, I'm starting on my twenty-fifth year and I would say over the years the hospital has progressed in such a way to make these decisions easier for us as medical staff. And we have more ways of having palliative care [where the patient is given care and comfort, but no lifesaving procedures when breathing and heart rate cease] so I guess that this process has been made easier over the years so I've learned from watching others and I've learned just from being in the trenches there. And I've learned also from the way we do palliative care now at the hospital so it probably is a process of all those things and watching some of my, I would say watching some of the older people. (Laughing) I'm probably one of the older people so anyway it's just something you learned over the way and the hospital helped us with that I think.

Willis spoke of having a good relationship with his peers. He says that he was fortunate to have good people mentor him. He observed and discussed situations with them. In the post interview session, Willis did speak of debriefing with colleagues after patients coded. He said that the nurses, physicians, and other RCPs would get together after the code and discuss the things that happened.

Experience is the intangible knowledge acquired in the context of the work environment. Schon (1987) comes best to describing experience as “swampy lowland, messy, confusing problems” confronting practitioners. Laura added experience as a way to learn. Earlier in our discussion Laura said that “age and experience” helped prepare her for the situations that might occur. Others also talked about experience. Even though Jimmy spoke of a situation where he and new graduate nurse needed to make a very difficult decision, he did speak of the importance of colleagues and past experiences helping form the way he approached ethical decision making. Asked the way he learned to make decisions since that very first difficult decision, Jimmy said, “a lot came from, I guess for lack of a better term, on the job training, working in a level three NICU, and being involved in or being aware of similar situations.” He admitted that when he graduated college that very little information was available in terms of ethical decision making in infants.

Connie acknowledges that she had a little ethics training in school, but most of her learning came from observing from experiences. Connie explains,

I think you know, in every health care profession you have some type of ethics class and they touch, I would say they touch on it. I think what you learn the most of is once you are in the field. Working in the field and seeing the different situations. But I think having

the basic background of ethics certainly helps, but actually being placed in a situation where you have to put that to use comes with experience.

Toni recognizes that formal education has done little in helping her make ethical decisions. Her ethical decision making resulted from her work environment. She states,

I don't feel like we've really gotten enough education in that area, to be perfectly honest with you. What I've gotten I've kinda learned through the nurses, just my own basic common sense, and humanity. People watching a loved one passing away is very difficult for them. So you kind of put yourself in their situation to a degree, not so much that you get emotional but so much that at least you can empathize with them. And that's kind of what a lot of us has done. I really think that we need a little more, like I said, a little bit more education than that area, but I can't say I know of any one that has ever done anything improperly, and been chastised for it, so I guess what we are doing works for now.

She acknowledges that she is influenced by colleagues and work experiences, but would like more continuing professional education in the area of ethical decision making.

Most hospital based Ethics Committees have members from various disciplines. Physicians, RCPs, Nurses, and Pharmacists are but a few of the members that may make up an Ethics Committee. Outside members may also be a part of this committee. Clergy and Psychologists are some of the members that may be internal or external to the hospital's Ethics Committee.

Mary was placed in a situation where a blood specimen was analyzed, but not ordered. According to policy, the laboratory personnel did not report those items that were not ordered. One of the lab results that were not ordered was a critical value, which could have been

detrimental to the patient. Mary had to make a decision as to whether follow policy or disregard the policy. Even after the occurrence, Mary wanted clarification from the Ethics Committee on the dilemma. She states,

First of all they validated the concern. It's made up of, it's a good interdisciplinary committee made up of physicians, nurses, ethicists, a lawyer, social workers. You know a good interdisciplinary group. They talk about it and then say ok a, b, c, d, e, f, g here's your answer. We talk about it and say here are some suggestions. Take this back to your department and discuss it. And that is exactly what I did, and I brought it back to the department and the department went a, b, c, d, e here is what we're going to do.

Mary appreciated the time and energy spent by the Ethics Committee to solve what she saw as a big problem with a policy.

Ray mentioned an ethics committee where he works as helping form his ethical judgment. He acknowledges,

I have been in the past on the ethics committee for fifteen years and going to various lectures and hearing various cases over the years has helped. Also, just going to different lectures concerning end of life, scenarios and end of life decisions helped in this situation. I think it helped a lot.

But not every hospital utilizes the Ethics Committee for common ethical decisions. Toni describes a different approach for an ethic committee. Individual committee members will provide guidance. The chaplain at her hospital comes around and speaks to the healthcare team regarding some of the chronic patients in end of life situations. She recognizes that the science of healthcare is surpassing ethics training and ethics is "scrambling to keep up." She is right that what we are doing may be working to a point, but we need to prepare for future events. As

technology increases, and patients in hospitals become older and sicker, will what we do work then?

Summary

This chapter presents the findings in the research conducted to understand how Respiratory Care Practitioners learn to make ethical decisions. The themes that emerged from the data included (1) common ways that RCPs learned to make decisions in ethical dilemmas, (2) the decisions made occurred in a short time frame, and (3) the dilemmas happened in intensive care units.

Although the participants claimed they learned to make their decisions in a number of ways, learning from colleagues was the most common way they learned. These participants were involved in situations where they observed Physicians, Nurses, and other RCPs making ethical decisions and learned from those situations. The participants were able to see the outcomes made by others and form their ways of making decisions in ethical dilemmas.

All of the participants described specific steps they used in making their decision in an ethical dilemma. In general, most of the participants identified a process of ethical decision making consisting of identifying the problem, generating a course of action, considering potential consequences in all of the courses of action, evaluating the selected course of action, and then reflecting on their decision. Even though these RCPs did not follow a specific, prescriptive model, the RCPs' decision making process did have commonalities with models described in the literature.

Most of the respondents talked about the short span of time to make their decision. When care givers are taking care of patients, thought is given to how to help the patient. When the patient's condition begins to deteriorate rapidly, RCPs are trained to think about those

procedures that will help save a life. When the decision is finally made to remove mechanical ventilation or to stop a resuscitative effort, the RCP must quickly reverse the way of thinking. Questions such as is it right to remove the ventilator or stop the resuscitation arise. In a matter of seconds the RCP must decide to follow orders or take another approach.

All participants told their stories in the setting of an intensive care unit. Patients with the most serious injuries and with the most severe illnesses are treated in intensive care. Advanced technology and medications are used to help patients recover from their injuries or illnesses. RCPs manage the ventilator that sustains many patients in these units. It makes sense that most ethical decision making occurs where advanced technology is used on the most critical patients. Life support is used so that body systems can heal. When the healing process cannot occur due to the severity of the injury or illness, life support is terminated. The implications of these themes will be discussed in Chapter 5.

CHAPTER 5

SUMMARY, CONCLUSIONS, DISCUSSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary

Respiratory Care Practitioners (RCPs), along with other health care professionals, are obligated to be patient advocates. If a physician's order seems unreasonable or has potential of causing patient harm, the RCP has the responsibility of questioning the order. If the physician does not provide a reasonable explanation, a chain of command exists for the RCP to seek a reasonable explanation. Even though the physician makes decisions and writes orders, these orders are not automatically followed without the RCP recognizing potential problems. The RCP also has decisions to make regarding sensibleness of orders. Many ethical dilemmas exist in medical practice including the practice of Respiratory Care Practitioners who must come to terms with these dilemmas routinely. The purpose of this research was to determine how Respiratory Care Practitioners (RCPs) learned to make decisions when presented with ethical dilemmas in their practice.

In order to best answer the questions posed in this research, the basic or generic qualitative research approach was employed. Participants were employed at three hospitals in the southeast. Fifteen RCPs with a minimum of three years' experience were interviewed on the basis of their experience, their communication skills, and their willingness to describe ethical dilemmas they encountered. Semi-structured interview questions utilizing a conversational approach were used to probe the participants' experiences. Eight participants were interviewed in

the institution where they worked with seven participants interviewed in their home. All interviews were recorded and transcribed. After transcribing, relevant information was analyzed to identify categories and common themes. Conclusions were drawn from the data provided by the RCPs.

Previous chapters included discussion of the research topic, literature review, the research study design, and the findings on ethical decision making. This chapter includes the conclusions and discussions from analyzing the data along with implications from the research for practice and suggestions for future research.

Conclusions and Discussion

From the data I drew three conclusions. One conclusion involves the type of ethical dilemma the RCP faced. The second conclusion entails the process RCPs go through to make ethical decisions. The third conclusion addresses how RCPs learned to make decisions in ethical dilemmas.

Conclusion One: The Prominent Ethical Decision Discussed by This Sample Was Life and Death Situations.

Respiratory Care Practitioners are asked routinely to make decisions in ethical dilemmas. Even though most understand the importance of these decisions, they are still viewed as an abstract process. Carroll (1996) writes,

It is easy to visualize ethical decision making as an abstract process, far removed from the duties and responsibilities of the typical workday. Even though RCPs are guided by a code of ethics that has been adopted by their professional organization, the tendency still exists to view ethical decision making as an abstract process. This is unfortunate since numerous ethical decisions are made routinely by the average healthcare practitioner on a daily basis. (p. 41)

Ethical considerations are at the core of health care. Jarvis' (1997) punctuates this perspective in his writing. The health care profession has always been viewed upon as being a noble profession. Health care workers are viewed as placing their patients' well-being above their own. Even the Hippocratic Oath is abundant with ethical ideologies. The one mainstay of the Hippocratic Oath, which we still recognize today, is that practitioners will "do no harm". Carroll (1996) and Edge and Groves (1994) describe ethical principles in healthcare including autonomy, beneficence, confidentiality, fidelity, justice, nonmaleficence, quality of life, sanctity of life, utilitarianism, and veracity.

Beauchamp (2003) identifies four general influences when health care workers make ethical decisions. Those four general influences are autonomy, non-maleficence, beneficence, and justice. Autonomy deals with a person being capable and competent to make decisions. Non-maleficence refers to doing no harm to an individual. Beneficence refers to doing good for an individual. Justice refers to following rules or laws.

End of life decisions occur frequently in intensive care units. Describing the statistics for life and death decisions, Prendergast and Luce (1997) state, "studies have estimated that withholding or withdrawal of life support precedes 40 to 65% of deaths in intensive care facilities" (p. 15). Discontinuing mechanical ventilation is only a part of the total deaths attributed to withdrawing life support. Prendergast and Luce (1997) continue, "The most common intervention withheld and withdrawn was vasopressor agents, closely followed by mechanical ventilation" (p. 17).

End of life decisions are especially difficult for the RCP. When an order is given to terminate mechanical ventilation, it will be the RCP that must discontinue this life sustaining equipment. Fremgen (2012) states, "Healthcare practitioners often find it more difficult to

withdraw treatment after it has been started than to withhold treatment (p. 327). Edge and Kreiger (1998) concur when they state, “Few legal or ethical problems within the area of health care cause the same degree of moral anguish as that of withholding or withdrawing life support” (p. 157). RCPs are taught to diagnose and treat patients to preserve life. When the time comes that treatment is futile, RCPs have a hard time adjusting to a change in course. Edge and Krieger (1998) state, “Often in cases involving life support, the desire to preserve life comes into direct conflict with the duty to alleviate pain and suffering” (p. 157).

In research by Cobanoglu and Algier (2004), end of life decisions, communication and hierarchical problems, and social problems were the three ethical problems experienced by physicians and nurses in intensive care units. Others also support that the main ethical problems in the health care environment related to end of life issues, communication issues, and social issues (Lesage 2001, Erlen 1997, Soderberg 1993 Soloman 1993, & Grundstein 1992). End of life issues were the number one problem in the Cobanoglu and Algier (2004) study, which includes removing patients who have no hope of recovery from mechanical ventilators.

According to Cobanoglu and Algier (2004), communication and hierarchical problems were the second most common problem and involves the use of conflicting communications given by physicians to health care providers. Social problems were the third most common ethical problem and this category includes limited resources and staffing.

Conclusion Two: Respiratory Care Practitioners Used a Process for Making Decisions in an Ethical Dilemma That has Commonalities to Models in the Literature.

Brockett (1988) described the decision making process as one in which the decision maker can be unreflective with the decision based upon hunch, tradition, organizational hype or other factors or one that is based upon a consistent, defensible, philosophical position. Other

authors also believe that the decision should involve a well thought out process (Merriam and Caffarella, 1999; Brockett, 1988; Carroll, 1996; Edge and Groves, 1994; Starratt, 1994; Sork, 1988; Laszniak, 1983; Shea, 1974).

Brockett (1988) describes a process for ethical decision making that underscores the complexities that are inherent in professional practice. This process differentiates among the dimensions of ethical practice. At the core of the process is a personal value system with consideration of multiple responsibilities encompassing this core. According to Brockett and Heimstra (2004), value systems “form the beliefs that, consciously or unconsciously, educators carry with them in their practice” (p. 14). The inner dimension refers to the various responsibilities that professionals possess. These responsibilities may be to the institution, professional organization, stakeholders, and to themselves. The outer level consists of operationalization values. Operationalization values are the place where practice and values meet. In the daily routine of a RCP, the RCP’s core values and the institutions policies are likely to influence the decisions made at the bedside.

Brockett’s (1988) process does not describe specific steps for ethical decision making. Many participants of this research did not use Brockett’s components for making the decision. Ray, for example, described a process where the problem was identified. Information was gathered. Input from physicians regarding the patient’s prognosis was considered. Determining a solution that balanced accepted medical practice and the family’s desires was at the fore thought of Ray’s decision. Even after reformulating the question to delve into the area of values, Ray did not mention his value system or the responsibility of the institution as a part of his process.

Whereas Brockett and Heimstra’s (2004) model is a theoretical model, Miller and Davis’ (2004) model is a step by step process. The process consists of identifying the problem, applying

a code of ethics, determining the nature of the dilemma, generating a course of action, considering potential consequences in all of the courses of action, and evaluating the selected course of action. None of the participants of this research mentioned applying a code of ethics to the process.

Other authors describe similar processes (Cottone & Claus, 2000; Corey, Corey & Calianan 1998; Forrester-Miller & Davis 1995; Healy, 2003; Keith-Spiegel & Koocher 1985; Mattison, 2000; Shea 1978; and Steinman, Richardson, & MeEnroe, 1998) to Miller and Davis (2004). Some of the differences in these authors decision making process were associated with the steps involved in making the decision. For example Corey, Corey, and Calianan's (1998) process did not include reflecting on the process after a decision was made. Forrester-Miller and Davis' (1995) process did not involve communicating with peers regarding decision making.

Shea (1974) is the most detailed in his approach to ethical decision making. Shea describes a step by step process for ethical decision making. His steps include 1) the need to make ethical decisions, 2) the opportunity to make an ethical decision, 3) recognition of the lens through which the ethical decision is being made, 4) information gathering, 5) dealing with the consequences, and 6) reflecting on the action of the decision. However, the participants did have the opportunity to gather information, make an decision in an ethical dilemma, and deal with the consequences of their decision.

Brockett's (1988) approach was not as detailed, but he did emphasize reflecting on the process. He writes, "As practitioners reflect on the ethical content of their choices, they will encounter dilemmas that should be resolved" (p. 37). As suggested by Sork (1988), "one needs to periodically review his or her ethical principles and reexamine his or her usual patterns of thought to prevent some social or personal injustices that can occur." And Shea (1978) reasons,

"without means of validation, one's actions are only actions. Their interpretation becomes statements of principles or standards only when a means of validation exists for them" (p. 122). Ethical decisions are based upon our philosophy of life or our "value system." In order to determine our "value system," we must introspectively reflect on what is important to us. Those things that are important must be imbedded in a standard or principle. Shea (1978) describes this principle as a statement of truth which issues from scientific facts or philosophical concepts and theories which serves as a guide for actions or decisions concerning the education and or welfare (right or good) of persons.

Kidder's (1995) views are a little different than those stated above. He sees ethical dilemmas as right versus right events. Right versus wrong decisions are clear for most of us to make most of the time. However, right versus right decisions are the tough ones to make. According to Kidder (1995), in order for a "right vs. right" situation to exist, the situation must meet at least one of four paradigms. These paradigms are 1) justice vs. mercy, 2) short - term vs. long - term, 3) truth vs. loyalty, and /or 4) self vs. community. Once the situation fits into one of these paradigms, then the practitioner can help solve the dilemma by using a care based, rule based, or end based approach to the dilemma.

Kidder (1995) explains a process for these right versus right dilemmas. Kidder's model (2005) involves defining the problem, identifying the concepts and ideas, performing a relevant test to determine right versus wrong issues, performing a relevant test to determine right versus right issues, developing test or prototypes, and then producing a solution. Kidder (2005) also identifies reflection as a component of his model. Even though many participants recognized that more than one decision could be considered "right," none mentioned the precise steps that

Kidder (2005) used. No participants mentioned performing tests to determine right versus right issues or developing prototypes in their resolution to the dilemma.

Making ethical choices can be a haphazard event, or a well-planned process. The participants of this research described a process they went through to make the ethical decision. These processes described by the participants demonstrated commonalities with models found in the literature. All participants identified the ethical dilemma and either had the patient's information or gathered the information needed to make the decision. None of the participants referred to ethical theories, although many described the ethical principle of quality of life. Most of the participants described the potential consequences of their actions, and a many described reflecting on their experiences. The RCPs never mentioned a specific decision making model that they used, instead they relied upon their colleagues and their experiences for a process of decision making. In this context the process of decision making by the participants in this research varied. The common steps with the models in the literature as described by the participants were (1) gathering important information regarding the patient, (2) taking into account the feelings and wishes of others in the specific situation, (3) envisioning the options, (4) placing the decision in context, and (5) relying on other experiences.

Conclusion Three: Respiratory Care Practitioners Learned to Make Decisions in Ethical Dilemmas Mostly from an Informal Learning Environment.

Most of the RCPs interviewed stated that the process of making decisions in ethical dilemmas was learned while they were on the job. Connie seems to place this in perspective when she says, "I think having the basic background of ethics certainly helps, but actually being placed in a situation where you have to put that to use comes with experience." Marsick and

Watkins (1990) see professionals learning by formal, informal and incidental learning.

According to the authors (1990),

Formal learning is typically institutionally sponsored, classroom – based, and highly structured. Informal learning, a category that includes incidental learning, may occur in institutions, but it is not typically classroom-based or highly structured, and control of learning rests primarily in the hands of the learner (p. 12). Informal learning is learner centered, and Marsick and Watkins (2001) describe it as “usually intentional but not highly structured” (p. 25).

Informal learning is derived from self-directed learning, mentoring, preceptors, trial and error, and networking. Writing about informal learning Marsick and Watkins (2001) identify examples such as “networking, coaching, mentoring, and performance planning that includes opportunities to review learning needs” (p. 26). Medical education uses mentors and preceptors to enhance informal education. This form of learning is not as planned or structured. It is learner directed as opposed to teacher directed. RCPs are routinely placed in situations where ethical decisions need to be made. Even if they were taught about ethics in college, it is the context of the situation that enhances meaning. RCPs learn from physicians, nurses, other RCPs, family, and patients in the context of these situations.

A type of informal learning is incidental learning. Incidental learning is learning that is not planned. Again, Marsick and Watkins (2001) describe this learning as “a byproduct of some other activity” (p. 25). As RCPs treat terminally ill patients, discussions occur amongst colleagues. Family members also discuss feelings and fears about a loved one in an intensive care unit. The patient sometimes talks of their wishes and their hopes. These interactions produce knowledge that affects the decisions that RCPs must make in end of life scenarios.

Eraut (1995) acknowledges that little is known about continuing professional education. Educators know about the structure and rigors of formal education, but when it comes to learning after the professional lands the job, educators are less knowledgeable of professional learning. Formal professional education can provide for theory, and theory works well in practice if everything falls into place. Formal professional theory works when the situation is well defined. In professional practice, not every situation is well defined. What does the professional do at this point? According to Eraut (1995), professionals will rely on what they have learned on the job. The pressures of policy and getting the job done will make the professional leave the theory on the shelf. Theory may not apply when the situation differs from what is taught in formal education. Ethics is an area where Eraut thinks that formal education may hinder the professional from handling situations very well. Again, if a case is presented in the formal educational environment involving strict ethical rules, how will the professional react when the organization violates those rules or a dilemma occurs? Eraut (1995) writes, “ To discuss moral dilemmas arising from casework seems relevant and straightforward, until one recognizes that many proposed courses of action conflict with organizational policy or with professional norms” (p. 123).

In the clinical environment, not all factors can be controlled. What may seem as a precise ethical theory in the classroom becomes another matter treating patients in an uncontrolled environment. Schön (1987) describes the balance between technical knowledge and artistry in professional learning. He gives examples in professions such as coaching, architecture, and music, but this balance of knowledge and artistry is also true in Respiratory Therapy. Even though we in the medical field like to believe that we base our decisions solely on science, we recognize that a part of medicine is an art. Schön understands that technical knowledge is not

enough for the professional to perform his/her work. Situations will arise that do not follow what is written in books. Schön (1987) describes these situations when he writes, “In the swampy lowland, messy, confusing problems defy technical solution” (p. 3). Even though science is the basis for much of the diagnostics and treatments in medicine, a good practitioner will rely not only on facts, but on intuition and feelings in difficult situations. Even though we in medicine depend greatly on science, when things get “messy” it is usually the art that helps the RCP make decisions in ethical dilemmas.

RCPs are warned against developing attachments to patients. As hard as we try, we do develop relationships with our patients and the family members of our patients. John mentioned relationships with family members. When describing how he learned about the process he used, he said he learned from being around patients’ families where these decisions have previously been made. Jarvis (1997) describes these relationships as the principal aspect of ethical considerations. He describes relationships with the "Other". The “Other” can be a living being, an individual person, or a spiritual being. According to Jarvis (1997), once the “Other” comes into contact with us, then an ethical relationship begins. This relationship opens the doors for ethical dilemmas where decisions have to be made. Also once this relationship begins, the RCP may find opportunities to learn from the actions and interactions of the family members when an ethical dilemma arises. Starratt (1994) supports the position stating that is a sense of responsibility that urges us to think of others. The ethical person is connected. Jarvis (1997) states, "It is significant that whatever the relationship, whoever the people and whatever the historical time, this argument still applies. It is for these reasons that it can be claimed that the basis of moral value is that it is universalisable" (p. 35). The "universal good" that Jarvis describes is caring for the “Other.” Jarvis applies this ethical relationship to training, teaching, self-directed learning, distance learning, and mentoring.

Jarvis adds another factor other than learning from people. He recognizes something in the experience is important in the learning process. Jarvis (1997) writes,

What is called for is an approach to learning that enables people to recall their own experiences of being cared for, and their experiences of caring for others, and realizing that the world would be a better place - irrespective of either social structures or social change - if individuals living within whatever structures that exist do so out of the concern for the Other. (p. 171)

Whether it is the context that makes the difference or some intangible factor, experiences do help RCPS in the decision making process.

All of the conclusions have a basis in adult education. With most RCPs participating in life and death situations, CPE may be needed to identify and bring to the full attention of the RCP the ethical importance of these issues.

Implications for Practice

This research confirms the need for adult educators to actively participate in the education and training of RCPs so they can become better at decision making in ethical dilemmas. This research also clearly demonstrates the need for institutions to provide resources to help clinicians in efforts to improve the ethical decision making process, such as mentoring, debriefing after a decision is made, and a structured educational process.

For educators of Respiratory Care Practitioners in the classroom or in the work environment, this research has other implications. To begin with, RCPs have a very general statement of ethics and professional conduct (a code of ethics) that may address a few non-specific situations. This code includes patient confidentiality, practicing medically accepted methods, and a general statement about RCPs exposing unethical conduct. This code of ethics needs to be strengthened, for example a more detailed code of ethics, a code of ethics that meets

today's ethical dilemmas, and a code that is specific to the practices of respiratory care. Strong codes of ethics appear in the medical profession. The RCP code of ethics could be modeled after the code of ethics of the American College of Health Care Administrators. The American College of Health Care Administrators' code of ethics includes expectations and proscriptions to the code. RCPs need to reevaluate their code of ethics that was adopted in 1994 and revised in 2000. The code of ethics needs to be written to meet the challenges RCPS face today, for example limited manpower resources and limited equipment resources. Once the code of ethics is rewritten, RCPs then need to be educated on the changes of the code.

In order for RCPs to be able to make medical ethical decisions, a strong foundation for the basics must be laid. Like with many health related procedures, this foundation would best be laid in a formal or structured environment. The classroom environment can be controlled and the RCP will have fewer distractions than in a clinical environment. This foundation should include discussions on codes of ethics, ethical theories, ethical principles, and specific case studies. The RCP needs to understand the perspectives of various codes of ethics, for example the code of ethics of the American Nursing Association and the American Medical Association. These codes of ethics are presented to the learner with explanations and examples of each principle. Next theories of ethics are described. The various theories will be the perspective that the RCP will frame the principles. Case scenarios will be presented and discussed to begin placing the dilemmas in context. To continue the learning process, RCPs would begin looking for ethical dilemmas in the clinical environment and discuss these dilemmas with educators or veteran RCPs.

Models do exist for ethical decision making. Degree providing colleges need to continue to offer ethics, but incorporate ethical decision making in the curriculum. Within the RCPs formal education, two organizations exist that determine the educational direction of Respiratory

Care, the Committee on Accreditation of Respiratory Care (CoARC) and the National Board of Respiratory Care (NBRC). CoARC outlines the curriculum necessary for Respiratory Care.

Within the curriculum CoARC mandates that medical ethics be taught. CoARC, however, does not dictate the depth of medical ethics that is required, nor does CoARC define what the learner should know. CoARC leaves most of the RCP knowledge acquisition to the individual Respiratory Therapy programs and the NBRC. The NBRC is the national organization that evaluates all RCPs. The NBRC's testing matrix is extensive including all aspects of respiratory care. The exam items are based upon job analysis surveys across the nation. Nowhere in the matrix or the exam is ethical decision making evaluated. CoARC needs to specify that ethical decision making is a standard of accreditation. The NBRC has clinical simulations that tests the graduates decision making skills. The NBRC needs to add an ethical component to the clinical simulation to test ethical decision making.

Only Alaska does not mandate licensure for RCPs; however, all of the other states require licensure and earning Continuing Education Units (CEUs). CEUs must be maintained and reported when licenses are renewed. CEUs are usually obtained through continuing professional education. Houle (1980) writes, "Professional education is that which prepares one to practice a profession" (p. 87). Professional education consists of preservice education and continuing professional education. Even when CPE programs are given, very little time is devoted to solving ethical dilemmas. In 2007 and 2008, 108 continuing education hours were offered by Georgia, Alabama, Tennessee, South Carolina, and Florida, states that have licensure. Not one of these 108 hours was dedicated to ethics. The American Association of Respiratory Care (AARC) offers continuing education hours that can be earned on line and in webcasts. From July 17, 2003 until January 8, 2008, 112 continuing education hours have been provided. Not one of these

hours was dedicated to ethical issues involving practitioners making medical, ethical decisions. More CPE programs need to add medical ethics and ethical decision making into their seminars.

Dodge (1998) writes,

that a large body of “unintentional” learning exists within the workplace which is not the result of conscious decisions and lacks critical reflection on the possible outcomes. These learnings may have negative consequences that are at odds with stated or intended policy. It suggests actions which can be taken to identify and mitigate unintentional learning and their outcomes. (p. 109)

Marsick and Watkins (2001) concur with Dodge (1998) when they write, “it is easy to become trapped by blind spots about one’s own needs, assumptions and values that influence the way people frame a situation... Power dynamics may distort the way in which they understand events (p. 30).

CPE programs can offer a structured approach and process to decision making in ethical dilemmas. Marsick and Watkins (2001) see that adult educators can bring structure for practitioners to take advantage of learning opportunities. These programs could identify ethical dilemmas that RCPs face. This would provide a foundation for RCPs to build upon. The practitioner then could relate contexts within the clinical environment where they face ethical dilemmas and provide a better basis for the decision making process.

The RCP needs to debrief after an ethical decision is made. This debriefing would include all participants of the process, such as physicians, nurses, and the RCP. The situation would be discussed and reasons given for decisions. After debriefing the RCP would reflect upon the decision, the way it relates to the practice, and the way it relates to the code of ethics, theories of ethics, the medical principles and the ethical decision making process. The process of

reflection on practice seems sometimes to be a simple process, but the complexities are apparent. The processes that practitioners use vary with the severity of the situation.

Recommendations for Future Research

Further research is needed to determine to what extent ethics and ethical decision making is taught in the formal education of Respiratory Care Practitioners. Some of the participants of this research stated they did learn some ethics in the formal, classroom environment, but most said they learned decision making in ethical dilemmas informally. Within the RCPs formal education, two organizations exist that determine the educational direction of Respiratory Care, the Committee on Accreditation of Respiratory Care (CoARC) and the National Board of Respiratory Care (NBRC). CoARC outlines the curriculum necessary for Respiratory Care.

Within the curriculum CoARC mandates that medical ethics be taught. CoARC, however, does not dictate the depth of medical ethics that is required, nor does CoARC define what the learner should know. CoARC leaves most of the RCP knowledge acquisition to the individual Respiratory Therapy programs and the NBRC. The NBRC is the national organization that evaluates all RCPs. The NBRC's testing matrix is extensive including all aspects of respiratory care. The exam items are based upon job analysis surveys across the nation. Nowhere in the matrix or the exam is ethical decision making issues evaluated. The systematic evaluation of ethics in the college classroom would provide new insights. Educators could inform the accreditation agency to be more specific in ethics requirements that would include a deeper exploration of ethical dilemmas. Since the NBRC does job analyses regularly, administrators could ask for testing in the area of ethics to help ensure the competency of new graduates.

A second potential research consideration could be to determine the importance healthcare administrators and supervisors have regarding ethics and ethical decision making. Hospital administrators budget a significant amount of time and money maintaining the competence of healthcare practitioners. Additional time and money are spent on programs ensuring excellence in practice, customer relations, cost containment, and management initiatives. If hospital administrators thought making good decisions in ethical dilemmas was a worthwhile venture, a more structured approach to decision making would be needed. In other industries, such as business and public health, employee's ethics training is routine requirement. All of these programs are important for the public's perception of the institutions and the institutions' viability. The emphasis that administrators and supervisors place on ethics could enhance the behaviors of healthcare practitioners.

Another potential research project is an investigation on how ethical decisions are made in places that have excellent reputations in doing so. The first industry that comes to mind that has an excellent reputation in ethics is business. In business, an entire journal is devoted to ethics and is published several times per month. Professional lawyers have a strong code of ethics and an ethics committee that investigates the ethical dealings of lawyers.

Another potential investigation could be a quantitative study to identify the other dilemmas where RCPs make ethical decisions. Factors may include the availability of resources. At any given time, resources may be limited. One example is a pulse oximeter, a device to continuously monitor oxygen saturations in blood, may not be available when needed. The RCP makes a decision as to which patient will receive this technology and who will not receive it. The ethical principle dictates that we treat all patients equally. When each patient needs this specific piece of equipment, who is the RCP going to treat differently? When patient census is high and

more treatments are ordered than RCPs can carry out, triage occurs. The RCP must make the decision as to which patients receive therapy as ordered and which patients do not. RCPs make other decisions in ethical dilemmas other than life and death situations.

The participants of this research had more than three years' experience as RCPs. Research needs to be conducted into how RCPs with less than three years' experience learn to make decisions in ethical dilemmas. Even though this research was based on Benner's (1984) notion of experts in practice, RCPs with less than three years' experience are making some of these same decisions discussed in this research. Hospital orientation for new RCPs may range from three weeks to six months. After orientation, these "novice" RCPs are functioning independently. When ethical dilemmas arise, how do novices respond to these situations? How do novices learn to make a decision in ethical dilemmas?

REFERENCES

- Aiken T. (2002). *Legal and ethical issues in health occupations*. Philadelphia: W.B. Saunders Company.
- Allen, J. (2013). *Health law and medical ethics for healthcare professionals*. New Jersey: Pearson Education, Inc.
- Austin, Z., Marini, A., Glover, N., & Tabak, D. (2005). Continuous professional development: A quantitative study of pharmacists attitudes, behaviors, and preferences in Ontario, Canada, *American Journal of Pharmaceutical Education*, 69(1) 25–32.
- Austin, Z., Marini, A., Glover, N., & Tabak, D. (2005). Peer - mentoring workshop for continuous professional development. *American Journal of Pharmaceutical Education*, 69(1) 1–6.
- Babbie, E. (1998). *Survey research methods*. Belmont: Wadsworth Publishing Company.
- Benner, P. (1984). *From novice to expert*. Menlo Park: Addison-Wesley Publishing Company.
- Benner, P., Tanner, C., & Chelsa C. (1996). *Expertise in nursing practice: Caring clinical judgment, and ethics*. New York: Springer Publishing Company, Inc.
- Benner, P. (2001). Taking a stand on experiential learning and good practice. *American Journal of Critical Care*, 10(1), 60-62.
- Beauchamp, T. (2002). Methods and principles in biomedical ethics. *Journal of Medical Ethics*; 29, 269 – 374.

- Braunack – Mayer, J. (2001). What makes a problem an ethical problem? An empirical perspective on the nature of ethical problems in general practice. *Journal of Medical Ethics*, 27(2), 98-103.
- Brockett, R., & Hiemstra, R. (2004). *Toward ethical practice*. Malabar: Krieger Publishing
- Brockett, R. (1988). Ethics and the adult educator. In Ralph Brockett (Ed.), *Ethics in adult education* (pp. 1-16). New York: Teacher's College Press.
- Callahan, M. (1999). *Case study of an advanced technology business incubator as a learning environment*. UMI, UMI number: 9975124.
- Carroll, C. (1996). *Legal issues and ethical dilemmas in respiratory care*. Philadelphia: F.A. Davis Company.
- Carroll, B., & Buchholtz, A. (2008). *Business and society: Ethics and stakeholder management*. Ohio: South-Western Cengage Learning.
- Cervero, R. (1988). *Effective continuing education for professionals*. San Francisco: Jossey-Bass Inc. Publishers.
- Cervero, R. (1992). Professional practice, learning, and continuing education: an integrated prospective. *International Journal of Lifelong Education*, 11(2), 91-101.
- Cervero, R. (2000). Trends and issues in continuing education. *New Directions for Adult and Continuing Education*, 86, 3–12.
- Cervero, R. (2001). Continuing professional education in transition, 1981–2000. *International Journal of Lifelong Education*, 20(1/2), 16–30.
- Cervero, R., Miller, J., & Dimmock, K. (1986). The formal and informal learning of

- practicing engineers. *Engineering Education*, 77(2), 112-118.
- Cervero, R., & Wilson, A. (1994). *Planning responsibly for adult education*. Jossey-Bass Publishers: San Francisco.
- Cobanoglu, N., & Algier, L. (2004). A qualitative analysis of ethical problems experienced by physicians and nurses in intensive care units in turkey. *Nursing Ethics*, 11 (5), 444 – 458.
- Connally, R., & Light, K. (1991). An interdisciplinary code of ethics for adult education. *Adult Education Quarterly*, 4(4), 233-240.
- Corvey, R. (2003). *The role of listserv participation in the professional development of a nursing community of practice*. Unpublished dissertation: University of Georgia
- Cottone, R., & Claus, R. (2000). Ethical decision making models: a review of the literature. *Journal of Counseling and Development*, 78, 275–282.
- Cope, P., Cuthbertson, P., & Stoddart, B. (2000). Situated learning in the practice placement. *Journal of Advanced Nursing*, 31 (4), 850–856.
- Corey, G., Corey, M., & Callanan, P. (1998). *Issues and ethics in the helping professions* (5th ed.). Pacific Grove: Brooks and Cole Publishers.
- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: Sage Publications.
- Creswell, J., & Miller, D. (2000). Determining validity in qualitative inquiry. *Theory into practice*, 39(3), 124-130.
- Daloz, L. (1986). *Effective teaching and mentoring*. San Francisco: Jossey-Bass Inc, Publishers.
- Davis, N. (1998). Contemporary deontology. In Peter Singers (Ed.), *A companion to*

- ethics*. (pp. 205–219). Massachusetts : Blackwell Publishers.
- Daley, B. (2000). Learning in professional practice. *New Directions for Adult and Continuing Education*, 86, 33-42.
- Daley, B. (2000). Context: implications for learning in professional practice. *New Directions for Adult and Continuing Education*, 86, 33–42.
- Daley, B., & Mott, V. (2000). Continuing professional education: from vision to reality. *New Directions for Adult and Continuing Education*, 86, 80-85.
- Dancy, J. (1998). An ethic of prima facie duties. In Peter Singers (Ed.), *A companion to ethics* (pp. 219–229). Massachusetts : Blackwell Publishers.
- Dewy, J., & Tufts, J. (1932). *Ethics*. New York: Henry Holt and Company.
- Dillman, D. (2000). *Mail and internet surveys: The tailored design method*. New York: John Wiley & Sons Inc.
- DiMauro, N. (2000). Continuous professional development. *The Journal of Continuing Education in Nursing*, 31 (2), 49–62.
- Dodge, R. (1998). Unintentional learning and the occupational health and safety experience. *Education + training*, 40(3), 109–114.
- Edge, S., & Groves, J. (1994). *The ethics of healthcare*. New York: Delmar Publishers, Inc.
- Edge, S., & Krieger, J. ((1998) *Legal and ethical perspectives in health care*. New York: Delmar Publishers, Inc.
- Eraut, M. (2003). *Developing professional knowledge and competence*. New York: Routledge Falmaer
- Eraut, M. (1985). Knowledge creation and knowledge use in professional contexts.

- Studies in Higher Education*, 10(2), 117–131.
- Eraut, M. (1975). Promoting innovation in teaching and learning: Problems, processes, and institutional mechanisms. *Higher Education*, 4(1), 13–26.
- Erlen, J., & Sereika, S. (1997). Critical care nurses, ethical decision making and stress. *Journal of Advanced Nursing*, 26, 953 – 961.
- Fedorka, P. & Husted, G. (2004). Ethical decision making in clinical emergencies. *Topics in emergency medicine* , 26 (1); 52 – 60.
- Finch, E, Geddes, L., & Larin, H. (2005). Ethically-based clinical decision-making in physical therapy: process and issues. *Physiotherapy Theory and Practice*, 21(3), 147 – 162.
- Forrester-Miller, H., & Davis, T. (1996). A practitioner's guide to ethical decision making. Retrieved on March 27, 2007 from <http://www.counseling.org/counselors/practitionersguide.aspx>
- Fraenkel, J., & Wallen, N. (1996). *How to design and evaluate research in education*. San Francisco: McGraw Hill Inc.
- Fraenkel, J., & Wallen, N. (1996). *How to design and evaluate research in education* (3rd Edition). New York: McGraw Hill.
- Frankena W., & Granrose, J. (1974). *Introductory readings in ethics*. New Jersey: Prentice-Hall Inc.
- Freeman, M. (1993). Ethical practice contributes to professionalism in adult and continuing education. *Adult Learning*, 5(2), 9-10.
- Fremgen, B. (2012). *Medical law and ethics* (4th Edition). New Jersey: Pearson Education Inc.

- Gilligan, C. (1982). *In a different voice*. Cambridge: Harvard University Press.
- Goodin, .R (1998). Utility and the good. In Peter Singers (Ed.), *A companion to ethics* (pp. 241–248). Massachusetts : Blackwell Publishers.
- Gordon, J. C. (1993). Peeling onions: Some tools and a recipe for solving ethical dilemmas, *Adult Learning*, 5(2), 11-12.
- Gordon, W., & Sork, P. (2001). Ethical issues and codes of ethics: Views of adult education practitioners in Canada and the United States. *Adult Education Quarterly*, 51(3), 202-218.
- Grundstein-Amado, R. (1992). Differences in ethical decision making process among nurses and doctors. *Journal of Advanced Nursing*, 17, 129 – 137.
- Gunz, S., & Gunz, H. (2008). Ethical decision making and the employed lawyer. *Journal of Business Ethics*, 81, 927 – 944.
- Harris, D. (2008). *Contemporary issues in healthcare law and ethics* (3rd edition). Chicago: Health Administration Press.
- Healy, T. (2003). Ethical decision making: pressure and uncertainty as complicating factors. *Health and Social Work*, 28(4), 293–301.
- Hersh, R., Paolitto, D., & Reirner, J. (1979). *Promoting moral growth: from Piaget to Kohlberg*. _New York: Longman, Inc.
- Hill, R. (2004). *Ethics for citizenship in a technological world*. Illinois : McGraw Hill.
- Hopke, W. E. (1968). *Dictionary of personnel and guidance terms*. Chicago: Fergeson.
- Houle, C., Cyphert, F., & Boggs, D. (1980). Education for the professions. *Theory into Practice*, 26(2), 87–93.

- Illingworth, P., & Parmet, W. (2006). *Ethical health care*. New Jersey: Princeton Education, Inc.
- Jarvis, P (1995). Teachers and learners in adult education: Transaction or moral interaction. *Studies in the Education of Adults*, 27(1), 24-35.
- Jarvis, P (1997). *Ethics and education for adults*. Leiceister, England: National Institute of Adult Continuing Education.
- Jarvis, P. (1987). Meaningful and meaningless experience: towards an analysis of learning from life. *Adult Education Quarterly*, 37(3), 164-172.
- Jarvis, P., Holford, J., & Griffin, C. (1998). *The theory and practice of learning*. Sterling: Stylus Publishing Inc.
- Jonsen, A., Seigler, M., & Winslade, W. (1998). *Clinical ethics*. New York: McGraw Hill Inc.
- Keith-Spiegel, P., & Koocher, G. (1985). *Ethics in psychology*. New York: Random House.
- Kidder, R. (1995). *How good people make tough choices*. New York: William Morrow and Company, Inc.
- Kidder, R. (2005). *Moral courage*. New York: Harper Collins Publishers.
- Kimberly, M., & Wood, G. (1993). Surveying adult education practitioners about ethical issues. *Adult Education Quarterly*, 43(4), 243-257.
- Knox, A (2000). The continuum of professional education and practice. *New Directions for Adult and Continuing Education*, 86, 13-32.
- Kuhse, H. (1998). Euthanasia. In Peter Singers (Ed.), *A companion to ethics* (pp. 205–219). Massachusetts: Blackwell Publishers.

- Lawler, A. (2000). Ethical issues in continuing professional education. *New Directions for Adult and Continuing Education*, 86, 63-70.
- Laszniak, G. (1983). Business ethics: A manager's primer. *Business*, 3(1), 23-29.
- Lesage, P., & Portenoy R. (2001). Ethical challenges in the care of patients with serious illness. *Pain Medicine*, 2, 121 – 130.
- Marshall, C., & Rossman, G. (2006). *Designing qualitative research* (4th edition). Thousand Oaks: Sage Publications.
- Marsick, V., & Watkins, K. (1990). *Informal and incidental learning in the workplace*. New York: Rutledge, Chapman, and Hill, Inc.
- Massey, J. (1997). *A new approach: Making ethical decisions regarding adult learner issues*. ERIC: ED406634.
- Mattison, M. (2000). Ethical decision making: the person in the process. *Social Work*, 45(3), 201–212.
- McDonald, K., & Wood, G. (1993). Surveying adult education practitioners about ethical issues. *Adult Education Quarterly*, 43(4), 243–257.
- Merriam, S. (1998). *Qualitative research and case study applications in education*. San Francisco: Josey-Bass
- Merriam, S., & Cafferella, R. S. (1999). *Learning in adulthood*. Jossey-Bass Publishers: San Francisco, 369-387.
- Merriam, S., & Simpson, E. (2000). *A guide to research for educators and trainers of adults*. Malabar: Krieger Publishing Company.
- Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. Jossey-Bass Publishers: San Francisco.

- Mitchell, E. T. (1950). *A system of ethics*. New York: Schribner Publishers.
- Mott, V. (2000). The development of professional expertise in the workplace. *New Directions for Adult and Continuing Education*, 86, 23-31.
- Ng, K., & Cervero, R. (2005). Learning the boss' way: ownership, power, and learning in practice and in workplaces. *International Journal of Lifelong Education*, 24(6), 489–505.
- Parmet, W. (2006). *Ethical health care*. New Jersey: Pearson Education Inc.
- Patton, M. (2002). *Qualitative research and evaluation methods* (3rd edition). Thousand Oaks: Sage Publications.
- Pozgar, G. (2013). *Legal and ethical issues for health professional* (3rd Ed.). Burlington: Jones and Bartlett Learning
- Prendergast, T., & Luce, J. (1997). Increasing incidence of withholding and withdrawal of life support from the critically ill. *American Journal of Respiratory Critical Care Medicine*, 155, 15-20.
- Rachels, J. (1998). Subjectivism. In Peter Singers (Ed.), *A companion to ethics* (pp. 205–219). Massachusetts : Blackwell Publishers.
- Schneewind, J. (1998). Contemporary deontology. In Peter Singers (Ed.), *A Companion to ethics* (pp. 205-219). Massachusetts : Blackwell Publishers.
- Schon, D. (1987). *Educating the reflective practitioner*. San Francisco: Jossey–Bass Publishers.
- Shea, E. (1978). *Ethical decisions in physical education and sports*. Springfield: Bannerstone House.
- Singarella, T., & Sork, T. (1983). Questions of values and conduct: Ethical issues for

- adult education. *Adult Education Quarterly*, 3(4), 244-251.
- Sodergerg A., & Norberg A. (1993). Intensive care: situations of ethical difficulty. *Journal of Advanced Nursing*, 18, 2008 – 2014.
- Solomon, M., O'Donnell, L., & Jennings, B. (1993). Decisions near the end of life: professional views on life-sustaining treatments. *American Journal of Public Health*, 83, 14–23.
- Sork, T., (1988). Ethical issues in program planning. In R.G. Brockett (Ed.) *Ethical issues in adult education*, (pp. 34- 50). New York: Teachers College Press.
- Starratt, R. (1994). *Building an ethical school: A practical response to the moral crisis in schools*. The Farmer Press: Washington, D.C.
- Steinbock, B., Arras, J., & London, A. (2003). *Ethical issues in modern medicine* (6th Ed.) McGraw Hill: Chicago, IL.
- Steinman, S, Richardson, O., & McEnroe, T. (1998). *The ethical decision making manual for helping professionals*. Pacific Grove: Brooks and Cole Publishers.
- Tovey, P. (1992). Assuring quality: current practice and future directions in continuing professional education. *Studies in the Education of Adults*. 24(2), 125–143.
- Veatch, R. M. (1989). *Medical ethics*. Jones and Bartlett Publishers: Boston, MA.
- Walker, K. (1993). Values, ethics, and ethical decision making. *Adult Learning*, 5(2), 13-14.
- Watkins, K., & Marsick, V. (1992). Towards a theory of informal and incidental learning in organizations. *International Journal of Lifelong Education*, 11(4), 287–300.
- Withall, A. (1990). Celebrating informal learning. *Adult learning*, 2(4), 102-104.

Wines, A. (2008). Seven pillars of business ethics: toward a comprehensive framework.

Journal of Business Ethics, 79, 483 – 499.

Wong, D. (1998). Relativism: contemporary deontology. In Peter Singers (Ed.), A

companion to ethics (pp. 442–450). Massachusetts : Blackwell Publishers.

Zinn, L. M. (1993). Ethical decision making in professional and business practice, *Adult*

Learning, 5(2), 7-8.

APPENDIX A
AMERICAN ASSOCIATION FOR RESPIRATORY CARE
POSITION STATEMENT

AARC Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapists shall:

Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals. Actively maintain and continually improve their professional competence, and represent it accurately.

Perform only those procedures or functions in which they are individually competent and which are within the scope of accepted and responsible practice.

Respect and protect the legal and personal rights of patients they care for, including the right to informed consent and refusal of treatment.

Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.

Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.

Promote disease prevention and wellness.

Refuse to participate in illegal or unethical acts, and refuse to conceal illegal, unethical or incompetent acts of others.

Follow sound scientific procedures and ethical principles in research.

Comply with state or federal laws which govern and relate to their practice.

Avoid any form of conduct that creates a conflict of interest, and shall follow the principles of ethical business behavior.

Promote health care delivery through improvement of the access, efficacy, and cost of patient care.

Refrain from indiscriminate and unnecessary use of resources.

Effective 12/94
Revised 3/00

APPENDIX B

HOW DO RESPIRATORY CARE PRACTITIONERS
LEARN TO MAKE DECISIONS ABOUT ETHICAL DILEMMAS
INTERVIEW GUIDE (Used For All Participants)

Research question 1: Under what circumstances do RCPs engage in making decisions involving ethical dilemmas?

Interview questions for Research question1:

1. Would you describe a situation where you had to make an ethical decision?
2. What exactly was the situation?
3. Who was involved?
4. Where did this situation occur?
5. Have you been involved in a similar situation such as the one you described?

Research question 2: What is the learning process for RCPs engage who engage ethical decision making?

1. As you think back on that situation, describe for me how you learned to make a decision like that?
2. Will you describe for me the process that you went through to make that decision?
3. How did you learn about that process?
4. Describe any educational endeavors that you have participated in that may have helped you in this ethical situation?
5. Describe any institutional policies that may have helped you in this ethical situation?

6. After you made these decisions that we have been talking about, describe for me any reflection that you made about that decision, did you think about it later?
7. From your reflecting did you learn from that as you look back on those decisions you made?

Research question 3: How do contextual factors influence decision making in ethical dilemmas for RCPs?

1. Could you describe what may have influenced you as you were making this decision?
2. What has had the greatest impact on your ethical decision making process?
3. Reflecting back, what tools would have been helpful for you when making this ethical decision?

Have you used these tools since this time for other decisions involving ethical situations?