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Creating a Graduate Level Interprofessional Ethics Course for Health Science Students: A Systematic Approach

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Abstract

Interprofessional collaboration in practice is an important skill, but creating interprofessional courses is challenging. Healthcare ethics is ideal for interprofessional education because no one discipline has authority over the subject. Most ethics courses for health science students, however, are based on the expertise of the instructor. In an interprofessional course, it is difficult for an instructor from one discipline to divine the needs of students from another field. The purpose of this paper is to methodically develop a graduate level ethics course for health science students based on a systematic review of the literature. The results are clear recommendations for creating a meaningful interprofessional learning experience in healthcare ethics.

Keywords: bioethics, education, ethics, interprofessional, learning

Creating a Graduate Level Interprofessional Ethics Course for Health Science Students: A Systematic Approach

Ethics education is integral to modern healthcare education and clinical practice (Delany, Spriggs, Fry, & Gillam, 2010). Even so, healthcare professionals are often oblivious to the everyday ethical issues they must traverse (Benner, Sutphen, Leonard, & Day; Poikkeus, Numminen, Suhonen, & Leino-Kilpi, 2013). They are frequently unprepared to participate in ethical decision-making at the bedside much less in Institutional Review Boards (IRBs) or Hospital Ethics Committees (HECs) (Catlin, 2014). Additionally, healthcare professionals lack a common language to discuss ethical concerns and resolve quandaries. As a result, critical bioethical decisions often lack input from nursing as well as the allied health disciplines like physical therapy and social work (Brazg, Dotolo, & Backsher, 2014). This is concerning since healthcare professionals who fail to participate in ethical decision-making may develop moral residue that can lead to burnout, antipathy, and ultimately poor patient experiences (Hardingham, 2004; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014; Zuzelo, 2007). Interprofessional ethics education breaks down professional silos, improves patient care, and enhances collaboration between disciplines (Benner et al., 2010). There are opportunities to develop graduate level ethics courses for health science students that prepare them to articulate morally and ethically consistent positions and advocate for just care at a leadership level. This study systematically synthesizes the current literature on ethics education in healthcare. The synthesis is presented in methodological fashion using the Three Cs Model (Kalb, 2009) for curriculum development and course design. The result is an evidenced based graduate level ethics course that addresses the needs of the modern healthcare professional.

The Three Cs Model

The Three Cs Model (Kalb, 2009) is a conceptual method of program evaluation, development, and quality improvement. It is a systematic and comprehensive strategy for program development that integrates the 3 Cs, context, content, and conduct, inherent to successful learning programs. Kalb (2009) describes context as how programs relate to academic communities, students, and faculty. Examples of contextual elements include regionally or nationally recognized professional competencies and unique university missions and values. Kalb notes, "The content of the department is held together through the curriculum and instructional activities, which engage faculty and students in the learning about nursing" (p. 177). The *conduct* of a department is the continual assessment and quality improvement processes used to ensure correct program implementation. While Kalb's original work with the Three Cs involved program evaluation, the Model's usefulness in curriculum development, strategic planning, and course design is manifest. For example, the Three Cs Model is also used to develop new courses systematically. A helpful pneumonic, C-U-R-R-I-C-U-L-U-M (CURRICULUM), reminds instructors to consider context, understand learners, write goals, write objectives, identify content, choose methods and materials, unite resources, lead implementation, undertake evaluation, and monitor outcomes (Kalb, 2009). Considering course context and understanding learners addresses the first "C" of course development, Context. Leading implementation, undertaking evaluation, and monitoring outcomes address the Conduct of the course. The remaining points help instructors develop the content of the course. Table 1 shows how the CURRICULUM Model integrates with the three Cs. Approaching course design methodologically helps ensure a good fit with university values, national accreditation standards,

and faculty and student expectations. With Dr. Kalb's permission, the Three Cs Model is used as a scaffold to construct this study (K.A. Kalb, personal conversation, November 11, 2015).

Table 1

The Three Cs and the C-U-R-R-I-C-U-L-U-M Model

<u>Context</u>	
C	Consider context
U	Understand learners
<u>Content</u>	
R	wRite goals
R	wRite objectives
I	Identify content
C	Choose methods and materials
U	Unite resources
<u>Conduct</u>	
L	Lead implementation
U	Undertake evaluation
M	Monitor outcome

Note. The Three Cs Model integrated with the C-U-R-R-I-C-U-L-U-M Model. From "The Three Cs Model: The Context, Content, and Conduct of Nursing Education," by K.A. Kalb, 2009, *Nursing Education Perspectives*, 30, p. 179. Copyright 2009 by the National League for Nursing. Reprinted with permission.

Literature Review

The aim of this study is to answer the question, what is the best evidenced-based course design for an interprofessional, graduate level, ethics course for healthcare students? A systematic literature review was conducted on October 1, 2015. The CINAHL, MEDLINE, ERIC databases were utilized in an attempt to capture data from as many healthcare disciplines as possible. The search terms were *ethics*, *healthcare*, *education*, and *interprofessional*. Tangential searches were conducted in each database using the term interdisciplinary instead of interprofessional, but there were no changes in the search results. The search was limited to English-language academic journals published in the last 10 years. The search yielded 123 results pooled from the databases. Three additional publications were identified by the author and added to the results. The records were checked for duplicates using the online citation management system *Refworks*. Six duplicates were identified and eliminated. A total of 117 articles were identified for preliminary screening. Abstracts were reviewed for relevancy. At this point, 63 articles were excluded because they did not address the study's aim. Fifty-four full articles were retrieved. Each article was read and assessed for relevance, level, and quality using standardized Research and Non- Research Appraisal Tools (Dearholt & Dang, 2012, p. 238). As a result of individual article appraisal, 14 articles were excluded because they did not answer the educational practice question. The remaining 40 articles are included in this study (see Figure 1).

The appraisal identified 13 level III articles all of good or high quality. Most articles failed to achieve high quality because of limited sample sizes that reduced the generalizability of findings. Two high-quality level IV articles were identified, and 24 articles appraised as level V at either good or high quality; the text *Principles of Biomedical Ethics* (Beauchamp & Childress, 2006) is

seminal, and it is included in the review. The text, however, was not leveled (see Appendix A). The findings from each article were synthesized, and the results are presented in relation to Three Cs Model of course development.

Context

The first consideration in course development is context. The CURRICULUM Model encourages course designers to consider context along with understanding learners as the first steps in curriculum development. The same strategy applies to course design. Course context refers to how a course upholds university mission and values. It also describes an individual course's place within a learning community (Kalb, 2009). The purpose of a course is determined by the outcomes that learners ought to achieve. Therefore, course context may be determined by an evaluation of academic outcome competencies and discipline-specific accreditation requirements.

Course Context and Core Competencies

There is little evidence to suggest how to achieve discipline specific outcome measures in an interprofessional course design (Lin et al., 2013). Buelow, Mahan, and Garrity (2010) reflect consensus opinion stating, "The structure of universities and colleges largely reflects the traditional professional silos built by healthcare disciplines. Each discipline has its own curriculum which reflects the core competencies needed for safe practices" (p. 91). Nevertheless, healthcare ethics is tailored toward interprofessional education because it crosses discipline-specific boundaries. The difficulty arises when courses must be fit into existing curricula and mesh with established program outcomes (Buelow et al. 2010; Hanson, 2005). Harmony between competing competencies is, nonetheless, possible. Verma et al. (2009) describe significant similarities between the core competencies of individual healthcare

disciplines like medicine, social work, and pharmacy and suggest a harmonized conceptual framework for those disciplines. Although Verma et al.'s work is in Canadian healthcare, the concepts have wider applicability. For this course proposal, harmony need only be found in the core competencies surrounding values and ethics. Verma et al. suggest that identifying core competencies and establishing a shared vocabulary are the first steps toward harmonious interprofessional course design.

Fortunately, the accrediting agencies for nursing, physician assistants, physical therapists, social workers, and occupational therapists all have at least one competency that specifies ethics educational outcomes (AACN, 2011; AOTA, 2012, ARC-PA, 2010; CAPTE, 2015; CSWE, 2010; QSEN, 2012). The language used in each agency's competency statements are similar, but they are often discipline-specific (see Appendix B). For example, the Accreditation Review Commission on Education for the Physician Assistants (ARC-PA) states, "The program curriculum must include instruction on the principles and practice of *medical* [emphasis added] ethics" (ARC-PA, 2010, p. 18). Occupational Therapy curricula should "Demonstrate a knowledge and understanding of the American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics, Core Values and Attitudes of Occupational Therapy Practice, and AOTA Standards of Practice and use them as a guide for ethical decision making in professional interactions, client interventions, and employment settings" (AOTA, 2012, p. 38). Although there is significant overlap between each discipline's ethical competencies, a harmonizing element that unites the competencies with language applicable to all disciplines is crucial.

The Interprofessional Education Collaborative (IPEC) developed competencies relevant to collaborative practice education. The IPEC core competencies cover four domains: teams and

teamwork, interprofessional communication, roles/responsibilities, and values and ethics for interprofessional practice (IPEC, 2011). The competencies were developed by expert opinion and consensus from a variety of disciplines including nursing, pharmacy, and medicine. IPEC competencies flow from discipline-specific values and ethics education requirements, but they provide outcome measures that transcend any single discipline (IPEC, 2011). Additionally, the discipline-specific accrediting agencies evaluated in this study support interprofessional collaboration because each discipline requires collaborative practice and interprofessional communication be taught at accredited institutions. Some agencies, like the Council on Social Work Education (CSWE), have issued unanimous declarations of support for the IPEC competencies (CSWE, 2014). The competencies delineated by IPEC for values and ethics are listed in Appendix A. They provide program level competencies and context for interprofessional healthcare ethics courses at the graduate level (Ewashen, McInnis-Perry, & Murphy, 2013). Academic institutions that have not adopted IPEC competencies as part of their curricular development and accreditation review processes are encouraged to tailor course level outcomes to account for discipline specific program level ethics requirements.

Courses should be congruent with university mission statements. This author is academically affiliated with Saint Catherine University (SCU), a liberal arts university in Saint Paul, Minnesota, and the Henrietta Schmoll School of Health. The School of Health is directed by its mission statement to focus on “relationship centered care, socially responsible leadership, and interdisciplinary initiatives” (SCU, 2015). In this example, the School’s mission is congruent with IPEC competencies that also align with the ethical and interprofessional competencies espoused by the major disciplines represented at the School of Health (e.g. Physician Assistant, Physical Therapy, Social Work, Occupational Therapy, and Nursing). From a curriculum

development perspective, congruency between competencies and mission must be demonstrable. Because student learning objectives flow from program outcomes, there is a direct link between the university's mission and course level objectives.

Understanding Learners

Interprofessional learners present unique challenges to educators. Students drawn from many professions are more diverse than when only one discipline is represented. Additionally, Hanson (2005) notes that schedules from different disciplines often do not align. One discipline may have classes on Tuesdays and Thursdays while another holds sessions on Mondays, Wednesdays, and Fridays for example. Scheduling classes demands care so that they are accessible to students with oppositional course schedules. To make matters more complicated, students come to graduate level ethics courses with varying levels of ethical knowledge ranging from almost no exposure to regularly using ethics in practice (Delaney et al., 2010; Poikkeus et al., 2013). There is insufficient evidence to recommend either course level within a curriculum or whether the course should be compulsory or elective. In any case, using sound adult education theory is essential, and faculty should design andragogy to maximize learner self-direction and integration of relevant professional and life experiences (Candela, 2012).

Content

Content at the departmental level describes how a curricular framework unites learning activities, like individual courses, into a comprehensive program of study (Kalb, 2009). At the course level, content refers to writing goals, formulating objectives, identifying content, choosing methods and materials, and uniting resources. The course content is fundamental to course design. It is the what, how, and why of student learning.

Writing Goals and Learning Objectives

Some educators make subtle distinctions between goals and objectives. Goals may be broader than learning outcomes or objectives, but Fink (2013) argues that the two terms are the same. According to Fink, learning goals are "any statement describing what we want students to learn by the end of the course" (p. 38). This study adheres to Fink's definition of student learning outcomes and uses the terms goal, objective, and outcome interchangeably. There is also debate about the specificity of learning objectives. Should they be general or specific? Fink argues that either approach is acceptable. For interprofessional education, however, general learning outcomes allow instructors from different disciplines more control over their individual learning experiences. Therefore, the data synthesized from the systematic review of literature will be used to create and espouse general student learning outcomes (SLOs) which provide meaningful learning experiences. Instructors should develop class level objectives that correspond to the SLOs.

The importance of student knowledge, understanding and ability to apply ethical principles in practice is well represented in the literature. For instance, in a recent article by Loike, Rush, Schweber, and Fishbach (2013) the authors recommend that students be able to identify bioethical dilemmas and develop personal strategies for resolving them. Advocating for students to be able to identify and address ethical dilemmas is not a new one. In one study by Crisham (1985), the author analyzed 130 staff nurse interviews concluding that nurses must be equipped with a process for identifying and resolving ethical dilemmas Crisham explains,

> Specifically, courses should a) develop an awareness of moral and ethical dilemmas in one's own nursing practice; b) identify actions that reflect a moral or ethical position in various contexts of nursing; c) describe how moral and ethical beliefs influence behavior;

> d) relate selected moral and ethical theory to positon taken; e) specify own position on moral and ethical issues in nursing; f) describe basis for own position; g) identify the consequences of taking a position; and h) identify major social and cultural forces affecting moral and ethical issues in health care. (p. 42F)

Crisham continues by offering a systematic process for achieving these learning objectives. The SLOs advocated by Crisham in 1985 were prescient as Crisham's suggestions are echoed in SLOs developed for pharmacists. After an extensive literature review, Angel and Simpson (2007) developed learning goals that include introducing students to the key tenets of ethics, identifying ethics in everyday pharmacy practice, analysis of ethical dilemmas, and understanding the connections between personal and professional values and behaviors.

While there are any number of overlapping content areas for ethics across professions and disciplines, it is also abundantly clear that each also have their own unique learning needs. Delany et al. (2010) found that allied health professionals, like physical therapists and occupational therapists, need skills and knowledge in the areas of relationship building and interprofessional communication as well as valuing their personal sense of moral agency. Medical residents and by extension Physician Assistants have still other pertinent objectives. Goold and Stern (2006) report, "Our respondents point to informed consent, interprofessional relationships, family interactions, communication skills, and end-of-life care as core elements of an ethics curriculum for residents across all specialties" (p. 15). Agreeing with Goold and Stern, Pauls and Ackroyd-Stolarz (2006) conclude that medical residents need training on informed consent, assessing decision-making capacity, and communication between patients as well as within their collegial interactions. Practicing physicians view "resource allocation, insurance

interactions, and self-monitoring" (Goold & Stern, 2006, p. 16) as important ethical learning needs.

Themes overlap between disciplines. For instance, Crisham's (1985) directive to "describe how moral and ethical beliefs influence behavior" (p. 42F) corresponds to allied health professional's learning needs about their roles as moral agents (Delany et al., 2010). Within the literature, there are overarching educational needs revolving around ethical knowledge and analysis of biomedical issues, professionalism, interprofessional ethical communication, the provider-patient relationship, identifying and navigating ethical issues, and moral agency (O'Donnell, 2007; Pauls & Ackroyd-Stolarz, 2006; Zuzelo, 2007). These themes alone could provide the substance of a graduate level bioethics course. Such a course, however, would not be without controversy.

Although valid, the educational needs described above are derived from biomedical ethics. Biomedical ethical theories, like principalism, developed from the work of Beauchamp and Childress (2006), Callahan (1973) and others in the 1970s. Before the publication of Beauchamp and Childress' seminal work *Principles of Biomedical Ethics*, the ethics of care was based upon virtue ethics (Ewashen et al., 2013). As the biomedical ethical model gained preeminence, morality shifts from virtue ethics toward a set of universal principles, autonomy, beneficence, nonmaleficence, and justice (Ewashen et al. 2013) that create the tenets or principles of bioethics (Beauchamp & Childress, 2006). Principalist ethical theory is criticized for paternalism as it assumes the universality of autonomy and implies a hierarchal structure between values (Grisbrooke, 2015). Although principalism appeals to many healthcare professionals because it provides a rational method for solving ethical dilemmas, it tends to ignore context, underemphasize the importance of interpersonal relationships and the healthcare professional as

a moral agent, and overemphasize finding a solution to ethical dilemmas (Hardingham, 2004). Additionally, the biomedical approach to ethics is inclined to ignore everyday ethical comportment making it seem as though ethical issues occur as crises or dilemmas requiring resolution rather than commonplace interactions to be negotiated (Liaschenko, Oguz, & Brunquell, 2005). Finally, there are cultural differences in how ethics is applied in practice, and the universality of ethical principles like autonomy, for instance, is debatable. Konishi, Yahiro, Nakajima, and Ono (2009) state,

> Concepts such as patient autonomy, individual rights and advocacy are translated from English into Japanese and taught in nursing or bioethics classes. Although many people in the West espouse the philosophy of liberalism that separates self from other, people in Japan historically share the philosophy of relationship with many other East Asian countries, in which the self is viewed as part of a larger whole consisting of groups and relationships. (p. 626)

Although the biomedical framework remains the dominant ethical pedagogy, there are valid alternatives to principalism that include relational ethics and virtue ethics (Ewashen et al., 2013; Liaschenko et al., 2005).

The learning outcomes associated with relational and virtue ethics must be reflected in the learning outcomes for any graduate level ethics course. Indeed, many of the IPEC competencies beg the study of the virtuousness, professionalism, and the ethics of care. For example, IPEC VE1 requires that healthcare providers, “Place the interests of patients and populations at the center of interprofessional health care delivery” (IPEC, 2011). This competency points toward the primacy of the provider-patient relationship in ethical decision making. Biomedical ethical frameworks tend to diminish interpersonal relationships (Liaschenko et al., 2005). Verkerk et al.

(2004) contend that morality is a social construct stating, "The professional needs to develop the skills to see a moral shape, to understand the difference between her own perspective and that of others, and to respond well to what is there to be seen, if she is to become professionally competent" (p. 32). Thus, moral competency is predicated upon relationships and each stakeholder's perspective on morality, values, and ethics. Moral agency and critical reflection are central to ethical decision making in relational ethics.

Virtue ethics and the notion of professional integrity are important concepts for graduate level healthcare students to master, and they must be addressed in course level outcomes as character and professionalism heavily influence program level outcomes across disciplines. Cruess, Johnston, and Cruess (2002) contend,

> The contract between professions and society is relatively simple. The professions are granted a monopoly over the use of a body of knowledge, as well as considerable autonomy, prestige, and financial rewards – on the understanding that they will guarantee competence, provide altruistic service, and conduct their affairs with morality and integrity. (p. 10)

There are personal values expected of healthcare professionals (Rider et al., 2014). They include loyalty honesty, empathy, competence, wisdom, courage, and integrity. Healthcare providers do what is right by acting as virtuous moral agents (Bolsin, France, & Oakley, 2004). Moreover, these values are learned by students and exemplified in practice (Bolsin et al., 2004; Cruess et al., 2002). Holmes (2010) argues that ethical leaders possess self-knowledge, act consistently, communicate well, are compelling, and they are agents of change. Student learning objectives for graduate level ethics courses must, not only require that students acquire cognitive level knowledge about ethical decision making, but require substantive affective learning. Only by

unambiguously tackling the affective learning domain can students develop the value system demanded of healthcare professionals. Developing virtuous professionals may serve students well in practice as Pask (2005) reports that internal virtues like courage are essential to overcoming barriers to ethical practice.

There is little high-level data to suggest evidenced based learning objectives for graduate level healthcare ethics courses. Most of the available evidence is descriptive or has limited applicability due to small sample sizes. Nevertheless, the literature does identify some themes and topics that must be learned. Additionally, guidance on developing learning objectives may be found in university mission and value statements. For instance, Saint Catherine University's mission aims to create transformative leaders (SCU, 2015). The idea of creating transformational leaders in healthcare ethics is supported by Catlin (2014) who observes that preparing graduates to participate in ethics committees and instilling the importance of everyday ethical comportment should be part of any undergraduate curriculum. Graduate level healthcare ethics courses should, therefore, prepare graduates to assume leadership roles in Institutional Review Boards and other clinical ethics groups and inspire graduates to continue learning about healthcare ethics. In summary, the following learning objectives are recommended: (a) by the end of the course, the student will discriminate between contemporary bioethical theories; (b) students will formulate their own ethical decision-making strategies; (c) the students will develop awareness of everyday ethical issues in practice; (d) students will value the sanctity of professional relationships; (e) the student will display effective interprofessional communication on ethical issues; (f) the student will appreciate their role as moral agent; (g) the student will predict the outcome of ethical decision-making/intervention; and (h) the student will create a morally reflective practice (Table 2).

Table 2

Student Learning Objectives

By the end of the course, the student will …

1. discriminate between contemporary bioethical theories
2. formulate their own ethical decision making strategies
3. develop awareness of every day ethical issues in practice
4. value the sanctity of professional relationships
5. display effective interprofessional communication on ethical issues
6. appreciate their role as moral agent
7. predict the outcome of ethical decision making/intervention
8. create a morally reflective practice

Identify Content

Individual instructors bring with them a wealth of knowledge and expertise. It is therefore unproductive to prescribe content and teaching style in a rigid manner (Hanson, 2005). The literature illuminates, however, core elements integral to any interprofessional healthcare ethics course.

At a conceptual level, an important distinction between philosophical ethics courses and courses in healthcare ethics must be articulated. Austriaco (2011) argues that bioethics as a discipline within philosophical ethics started in 1973 when Callahan (1973) published the article "Bioethics as a Discipline." Callahan argues, "[bioethics] requires a willingness to accept the realities of most medical and much scientific life, that is, that at some discreet point and time all

talk has to end and a choice must be made, a choice which had best be right rather than wrong" (p. 68). Thus, healthcare ethics involves analysis of clinical situations where decisions that have profound and often immediate consequences must occur in real time. Hardingham (2004) offers a more contemporary working definition of bioethics,

> Bioethics involves critical reflection on moral/ethical problems faced in health care settings toward: - deciding what we should do (what actions are morally right and acceptable); – explaining why we should do it (justifying our decisions in moral terms); and – describing how we should do it (the method and manner of our response). (p.128)

An instructor that tries to condense all of ethical thought into a single semester does so at their peril and the student's expense. Concepts discussed in a healthcare ethics course must, therefore, be relevant to practice (Stoddard & Schonfeld, 2011) Bioethics is a discipline, healthcare ethics is a class with specific parameters if one is to create a meaningful learning experience.

For students to discriminate between bioethical theories, they must have foundational knowledge of each theory, but what students know about ethics is highly variable (Burkemper, Dubois, Lavin, Meyer, McSweeney, 2007; Delany et al., 2010). Most healthcare ethics courses begin with a top-down approach where a general introduction to each theory is provided, and then the theories are narrowed to examine individual issues or cases (Dahnke, 2014; Gabriele, 2011; Liaschenko et al., 2005; Loike et al., 2013). Ewashen et al. (2013) provide a summary of each dominant philosophical ethical framework—biomedical ethics in the form of principalism, relational ethics or the ethics of care, and virtue ethics. The authors apply each framework to an interprofessional practice scenario. The study aptly demonstrates how dogmatic adherence to a single framework may result in interprofessional discord. Ewashen et al. note, "Epistemologically, successful interprofessional collaboration-in-practice requires

acknowledging and legitimizing multiple ways of knowing, displacing dominant perspectives to surface alternatives that traditionally may have been operated as marginalized or subjugated" (p. 333). Although instructors may bring their discipline-specific points of view to the course (Liaschenko et al., 2005), they must deliver ethical content free of bias or risk students perceiving a hidden curriculum favoring one theory over another. Loike et al. (2013) argue that courses should "make students aware that bioethical analysis is not bound to existing theories and principles that may conflict with or trump another" (p. 702). Rather, instructors should strive to prepare students to formulate their own ethical decision-making strategies that are based upon sound theory. Level V evidence supports including the philosophical foundations of biomedical, relational, and virtue ethics in course design.

The strongest evidence uncovered in this analysis involves helping learners develop their awareness of everyday ethical issues. Across disciplines, Buelow et al. (2010) identified four areas of common ethical concern: uninsured/underinsured, moral and religious issues, public policies not controlling healthcare costs, and fiscal resiliency of organizations and providers. The Level III evidence Buelow et al. provide demonstrates high quality with a large sample group of 440 students that is also interprofessional, with students representing 14 different health disciplines. Moral and religious issues encompass many classic bioethical conundrums such as end-of-life care and advanced directives and informed consent which both Goold and Stern (2006) and Pauls and Ackroyd-Stolarz (2006) report are important learning topics for medical residents. At a *minimum*, courses in healthcare ethics should address end-of-life issues like withdrawal of life support and futile care, confidentiality, genomic ethics and reproductive issues, palliative care, organ donation, and informed consent (Burkemper et al., 2007). Controlling health care costs and fiscal resiliency create another cluster of ethical issues

identified by healthcare students. It involves resource allocation topics such as Medicare/Medicaid reimbursement and placing too much emphasis on profit instead of focusing on patient care. This cluster was identified mainly by healthcare administration students and allied health professionals who may feel that their treatment decisions are dictated by reimbursement potential (Buelow et al., 2010). However, resource allocation also applies to nurses who continually rank inadequate staffing as a serious ethical concern (Pavlish, Brown-Seltzman, Jakel, & Rounkle, 2012; Sauerland et al., 2014; Zuzelo, 2007). Consequently, there is evidence that just allocation of scarce resources is also a topic for inclusion. It is vital that topics important to learners be discussed in class if the course material is going to be meaningful. As Liaschenko et al. (2005) note, "In both didactic and practical settings, ethics instruction should begin with the identification of the moral and ethical concerns of students and an analysis of why they are a cause for concern" (p. 675).

Relationships, whether they are between professional and client or collegial, are central to healthcare ethics (Liaschenko et al., 2005). Helping learners achieve deeper understandings of professional relationships is fundamental. It is key to providing context and nuance to ethical decision making (Liaschenko et al., 2005). Verkerk et al. (2004) argue,

> moral competence is a matter of developing a set of skills, namely, seeing what is morally relevant in a given situation; knowing the particular point of view from which one sees it; understanding that others who are involved may see it somewhat differently; and, with those others responding to what one sees. (p. 32)

One of the most formidable arguments against the biomedical framework is that the theory's paternalistic view of healthcare ethics minimizes professional relationships when, in fact, relationships should be of paramount importance in any decision-making process. Hardingham

(2004) agrees, “For many people, and especially for women, life is not lived in a vacuum, where the decision-maker acts in isolation” (p. 133). Moreover, professionals need to interact with others, both patients and colleagues, to improve their capacities for moral reasoning because integrity is a relational process that requires dialog and self-reflection (Hardingham, 2004). Therefore, providing learners with the tools necessary to develop internal ethical awareness and personal values is essential to creating ethical professionals.

Bioethics lends itself, as a discipline, to a methodological system of inquiry and analysis. It is not surprising, then, that many ethics courses are taught using systematic ethical decision-making tools or methods (Manson, 2012). These analytical tools are prevalent in the literature as well as practice, but most of them reflect expert opinion rather than higher level evidence. Additionally, most ethical decision-making tools are rooted in ethical principalism, and, therefore, they often fail to consider or even perceive context. Manson (2012) proposes a different ethical tool based on published evidence which better accounts for situational context. Manson’s system uses the pneumonic CoRE-Values to help learners remember the steps of the analytical process: Code (Co), Regulations (R), E (Ethical principles), and Values. Students found the CoRE-Values method useful in linking theory to clinical practice and improving ethical awareness. Furthermore, it is used as a curriculum planning tool at Dundee University to teach ethics (Manson, 2012). The CoRE-Values Model in part uses codes to analyze ethical situations. Dahnke (2014) agrees that professional ethical codes, like *The Code of Ethics for Nurses*, for example, can be successfully used to teach healthcare ethics. However, the author also indicates that, “The proper [student-code] relationship is not one of simple rule following but of active engagement in order to autonomously handle not only simple ethical issues but difficult dilemmas” (p. 621). In other words, learners must understand the what, where, and why of

ethical codes for them to be meaningful frameworks for ethics education (Dahnke, 2014). Using ethical codes as a way of teaching healthcare ethics also provides a way to integrate discipline-specific ethical interpretation by helping members of different professions find common ethical ground (Cellucci, Layman, Campbell, & Zeng, 2011).

Dahnke (2014) articulates four problems with using professional codes to teach ethics that must be addressed. The author argues,

> These common criticisms should be addressed in order for learners to understand the limits of codes of ethics, to understand that they do not represent absolute truth about morality but the reasoned, educated views of experienced, thoughtful, and sincere members of the profession – and that the power and authority of the code resides in both the extent and limits of this reasoning, not in the authority of the architects of the code. (p. 615)

The same problems with using ethical codes apply to using systematic ethical decision-making tools to teach healthcare ethics. First, the interpretation problem is that no one ethical code could address every ethical issue encountered in practice. Therefore, professionals must be able to interpret the meanings behind the ethical code. Second, the multiplicity problem is encountered when a professional is beholden to more than one ethical code that may have competing interests. Third, the legalization problem is seen when learners understand codes, and by extension ethics, in terms of what is legal and what is not legal. The legalization problem can lead to Foucauldian Governmentality, which Dahnke describes as, “instead of practitioners formulating their ethical behavior themselves, within critical consultation of the code, they may be said to conform to pre-existing morality established by the profession” (p. 617). Lexification, or understanding healthcare ethics from a strictly legal perspective may lead to

oversimplification of complex ethical problems (Gabriele, 2011). Finally, the fourth problem is futility. The futility problem is the belief that an ethical profession does not need a code, and unethical professions will ignore a code. Dahnke indicates that futility occurs because codes are not readily enforceable; unless the codes themselves become a system of regulations designed to control behavior, which would not lead to ethical behavior, futility will ensue (2014). An additional criticism of using ethical codes or decision-making frameworks to teach healthcare ethics is that both tend to create the illusion that ethics exists to solve dilemmas when in fact it is a factor every day in every professional interaction (Liaschenko et al., 2005).

Manson (2012) articulates a compelling case for using ethical decision-making tools as a basis for teaching ethics while Dahnke (2014) describes a path toward using ethical codes to teach healthcare ethics by accounting for the problems inherent in using codes. It stands to reason that Dahnke's admonishments apply to ethical decision-making tools as well as codes, and a meaningful learning experience could be developed using either codes or ethical tools as a pedagogy. Conversely, dogmatically adhering to ethical codes and tools may lead to a superficial understanding of healthcare ethics (Gabriele, 2011). Currently, there insufficient evidence to support using this pedagogy over another approach. However, there is sufficient evidence to warrant inclusion and critical analysis of ethical tools, like CoRe Values, and professional codes of ethics in graduate level healthcare courses.

Choose Methods and Materials

There are numerous examples of how to deliver ethics courses in the literature. Angel and Simpson (2007) designed an ethics manual that is introduced at the beginning of pharmacy students' program of study. The manual corresponds to embedded ethical components within each pharmacy class. The manual is structured to provide on-going learning activities

throughout matriculation and into professional practice. In an example of teaching nursing and medical students together, Hanson (2005) reports, “The course consisted of a medical-school-style lecture component, using a variety of lecture formats, immediately followed by a small group component where about 10 students would discuss the readings, lecture and relevant ethical cases with a moderator” (p. 169). Still another example is offered by Holmes (2010) who describes teaching midshipman at the United States Naval Academy by using interactive multimedia simulations, classroom, personal, and professional interactions to teach leadership and ethics. Interprofessional problem-based learning (PBL) is reported in the literature. Lin et al. (2013) reports, “The interprofessional PBL curriculum for clinical ethics consisted of a 2-hour lecture, two 2 hour PBL tutorial sessions, and a 3-hour feedback session. These four sessions were carried out over 4 continuous weeks” (p. 507). Solomon and Geddes (2010) demonstrate that students can learn about professional roles and scope of practice through an entirely online learning module. Likewise, Stoddard and Schonfeld (2011) found no difference between online only healthcare ethics students’ participation and written work. Consequently, there is no compelling evidence that one delivery method or teaching style improves student outcomes, and no recommendations are evident as to what format works best for an interprofessional graduate level ethics course.

There is evidence that reflectivity is a key concept in healthcare ethics education (Eriksen, 2015). Eriksen (2015) observes, “reflective professionals must be able to reflect upon their own practice and acting [sic] to adjust this practice according to the insights gained through reflections” (p. 82). Active reflection in healthcare ethics education may be taught by using anchored ethical dialog. Students link clinical practice to ethical learning by reflecting on concrete cases. Instead of applying general ethical principles to cases, individual cases are

analyzed contextually (Eriksen, 2015). For example, students are taught the tenets of biomedical ethics in a lecture. In a subsequent class, students are given a relevant case study useful to practice. The learners discuss the case in teams and are guided toward discovering how a biomedical ethical framework applies to the case. Each learning interaction adds layers of complexity as new content and cases are introduced. Anchored ethical dialog is an example of problem-based learning. In ethics education, this is a bottom-up approach. Instead of applying ethical generalities to a specific case, a specific case is used to learn about how ethics is used in practice. Liaschenko et al. (2005) add,

> Our approach to ethics education begins not with grand theories or with cases of tragic dilemmas but with an attempt to understand the nuances of the provider patient relationship and the relationships between providers in the everyday world of health work, as well as careful understanding of our place in society as healthcare providers. (p. 674).

When using PBL as a method of teaching healthcare ethics, instructors must use caution not to portray ethics as isolated dilemmas, but as part of everyday life in healthcare. Whatever pedagogy is selected, it is essential that active reflection is explicitly taught as part of healthcare ethics education (Loike et al., 2013; Verkerk et al., 2004). There are additional obstacles to meaningful learning within an interprofessional environment, for instance, poor interdisciplinary communication. Saint Catherine University uses Team-Based Learning to enhance interdisciplinary communication and goal attainment with anecdotal reports of success (P.L. Finch-Guthrie, personal communication, October 29, 2015).

While instructors must be encouraged to design their own classroom experiences and assignments (Hanson, 2005), there are some evidenced based assignments evident in the

literature. Strawbridge, Barrett, and Barlow (2014) report that structured debates, when followed by a class discussion to ameliorate the potential for dichotomies, are useful in ethics education. Loike et al. (2013) describe a final examination where students must demonstrate "their ability to write a clearly argued case. Students must prove that they can develop a logical, structured approach to a specific problem or a general type of problem" (p. 708). While most graduate level ethics courses offered to nurses are not assessed by examination, most courses offered in medical schools evaluate comprehension by examinations (Burkemper et al., 2007). However, Stoddard and Schonfeld (2007) found that online students performed poorer on multiple choice examinations than did traditional classroom students. Therefore, multiple choice exams should be avoided in favor of constructed writing assessments in online and hybrid class formats. Regardless of the evaluation method selected, instructors must ensure that the evaluative tool or assignment determines whether or not students achieved the course learning objectives. Finally, Bolton (2015) notes, "Clinician-writers use artistic methods to question from outside their everyday walls, rather than aiming to create art. Reflective writers experiment with different voices and genres, for different audiences, paying attention to the identities of both the narrator and reader" (p. 133). Aesthetic writing and reading of literature stimulate reflection (Bolton, 2015) which is essential to ethics education in healthcare. Moreover, Verkerk et al. (2004) contend, "Because narrative of identity, relationships, and value play such a central role in our *moral* lives together, moral competence crucially depends upon *narrative* competence" (p. 32). Ethically competent professionals must see context and relate to ethical issues from multiple perspectives – what Crisham (1985) might call massaging the dilemma. Narrative writing is both a tool for developing context and critical reflection and a means of assessing competency.

Significant evidence is not available to suggest a particular text or reading assignments. However, Hanson (2005) suggests using an interdisciplinary ethics text if an adequate tome is available. Otherwise, use care when selecting readings so as not to alienate one discipline or show bias (P.L. Finch-Guthrie, personal communication, October 29, 2015). At the graduate level, a text may not be necessary. Loike et al. (2013) used journal articles and assessed comprehension by using an online discussion board.

Unite Resources

Interprofessional courses require the involvement of multiple instructors from diverse backgrounds, and scheduling can be challenging (Hanson, 2005). For example, room availability and suitability often scarcely considered in traditional course design may present significant problems in an interprofessional ethics course (Hanson, 2005; P.L. Finch-Guthrie, personal communication, October 29, 2015). By far the most difficult concern, however, is achieving academic consensus on course content and pedagogy. While the professional and interprofessional competencies discussed earlier offer some direction, at some point and time stakeholders must congress and decide when, where, and how the graduate level course should be taught at their university. One way of building academic consensus is the Modified Delphi technique. In this case, a list of stakeholders interested in developing an interprofessional graduate level ethics course for health science students could be compiled. The best practice recommendations delineated in this study could be broken-down into propositions. The propositions are dispersed to the stakeholders who rank them using a Likert scale and provide feedback. The results are analyzed. Another round of questioning helps determine the intensity of agreement within median responders, and so forth. After several rounds, a consensus may

emerge which can then be more readily discussed in committee (Sauter, Gillespie, & Knepp, 2012).

Conduct

Leading implementation, undertaking evaluation, and monitoring outcomes are on-going processes. Future opportunities for research based upon this course design include evaluation of learning outcomes for efficacy, developing accurate assessment tools for ethics courses, and discovering the best delivery methods and teaching strategies for interprofessional ethics courses. Additionally, while there is a great deal of research from physicians and nurses on this subject, contributions from other disciplines are scarcer. Physical therapists, physician assistants, social workers and educators in other health disciplines are encouraged to contribute to the interprofessional body of knowledge on this topic.

Conclusion

Creating interprofessional courses can be challenging, but it is an essential task (Hanson, 2005). It can be argued that interprofessional ethics education is superior to traditional formats (Hanson, 2005) and, therefore, should be strongly considered when determining what is necessary at each university (Webb, 2006). When offering an interprofessional course, including topics that are both compelling and essential to all involved disciplines requires careful review of the literature and a systematic approach toward course development. However, lest readers think they should create courses that are simply lists of biomedical issues, ethical theories, and case studies, the author has one final thought. Benner et al. (2010) call for moral imagination in nursing, and ethics courses demand it. In one case, Benner et al. analyze how one ethics instructor conducts ethics education, “her most important responsibility is to teach her students how to think ethically about taking care of patients, and how to separate their personal feeling

about patients from their professional responsibilities to them. Once students understand how to think about ethical problems, she believes, they can act in an ethically responsible way" (p. 170). In summary, well-rounded interprofessional ethics courses must integrate the three Cs of course development. Course developers must consider context in the form of discipline-specific competencies and university missions. Some order may be imposed upon competing competencies by using the IPEC competency statements as a catalyst for finding interprofessional accord. Course content must enable learners to accomplish student learning objectives (Table 1) which are derived from the needs of practicing healthcare professionals and health science students. Finally, the learning objectives dictate the topics and assignments that should be included in the course. Minimally, graduate level interprofessional ethics course should cover contemporary bioethical issues, provide foundational knowledge about bioethical philosophy, enhance the learner's personal value system, improve interprofessional communication about ethics, and inspire ethical practice. Course readings and assignments should emphasize active reflection to accomplish these broad goals. Ethics transcends discipline specific notions of hierarchy; in ethics, all stakeholders have a voice. As healthcare educators, providing future professionals with the knowledge and tools they need to fully participate in ethical decision-making can only benefit patients.

References

AACN. (2011). The essentials of master's education in nursing. Retrieved from http://www.aacn.nche.edu/education-resources/MastersEssentials11.pdf

Angel, L. A., & Simpson, M. D. (2007). Report of best practice: Development of an ethics manual as an integral component of undergraduate curriculum and application for graduates and practitioners. *Journal of Learning Design, 2*(1), 1-13.

AOTA. (2012). Accreditation council for occupational therapy education (ACOTA) standards and interpretive guidelines. Retrieved from http://www.aota.org/-/media/Corporate/Files/EducationCareers/Accredit/StandardsReview/guide/2006ACOTEStandardsInterpretiveGuide8-2012.pdf

ARC-PA. (2010). Accreditation standards for Physician Assistant Education. Retrieved from http://arc-pa.org/documents/Standards4theditionwithclarifyingchanges9.2014%20FNL.pdf

Austriaco, N. P. G. (2011). *Biomedicine & beatitude: An introduction to Catholic bioethics*. Washington, DC: The Catholic University of America Press.

Beauchamp, T.L., & Childress, J.F. (2008). *Principles of biomedical ethics.* New York and Oxford: Oxford University Press.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey Bass.

Bolsin, S., Faunce, T., & Oakley, J. (2005). Practical virtue ethics: Healthcare whistleblowing and portable digital technology. *Journal of Medical Ethics, 31*(10), 612-618.

Bolton, G. (2008). Boundaries of humanities: Writing medical humanities. *Arts and Humanities in Higher Education: An International Journal of Theory, Research and Practice, 7*(2), 131-148.

Brazg, T., Dotolo, D., & Blacksher, E. (2015). Finding A seat at the table together: Recommendations for improving collaboration between social work and bioethics. *Bioethics, 29*(5), 362-368. doi:10.1111/bioe.12106

Buelow, J. R., Mahan, P. L., & Garrity, A. W. (2010). Ethical dilemmas as perceived by healthcare students with teaching implications. *Journal of College Teaching & Learning, 7*(2), 85-92.

Burkemper, J.E., Dubois, J.M., Lavin, M.A., Meyer, G.A., McSweeney, M. (2007). Ethics education in MSN programs: A study of national trends. *Nursing Education Perspectives, 28*(1), 10-17.

Callahan, D. (1973). Bioethics as a discipline. *Hastings Center Stud, 1*, 66-73.

Candela, L. (2012). From teaching to learning: Theoretical foundations. In D. M. Billings & J. A. Halstead (Eds.). *Teaching in nursing: A guide for faculty* (4th ed., pp. 202-242). St. Louis, MO: Elsevier Saunders.

CAPTE. (2015). Standards and required elements for accreditation of physical therapist education programs. Retrieved from

http://www.capteonline.org/uploadedFiles/CAPTEorg/About_CAPTE/Resources/Accreditation_Handbook/CAPTE_PTStandardsEvidence.pdf

Catlin, A. (2014). The hospital ethics committee and the nurse. *Advances in Neonatal Care: Official Journal of the National Association of Neonatal Nurses, 14*(6), 398-402. doi:10.1097/ANC.0000000000000151

Cellucci, L. W., Layman, E. J., Campbell, R., & Zeng, X. (2011). Integrating healthcare ethical issues into IS education. *Journal of Information Systems Education, 22*(3), 215-224.

Crisham, P. (1985). MORAL: How can I do what's right? *Nursing Management / Critical Care Management Edition, 16*(3), 42A-42N.

Cruess, S. R., Johnston, S., & Cruess, R. L. (2002). Professionalism for medicine: Opportunities and obligations. *The Medical Journal of Australia, 177*(4), 208-211.

CSWE. (2010). Education policy and accreditation standards. Retrieved from http://www.cswe.org/File.aspx?id=41861

CSWE. (2014). Interprofessional educational collaborative. Retrieved from *http://www.cswe.org/CentersInitiatives/CurriculumResources/76865.aspx*

Dahnke, M. D. (2014). Utilizing codes of ethics in health professions education. *Advances in Health Sciences Education, 19*(4), 611-623.

Dearholt, S. L., Dang, D. (Eds.). (2012). John Hopkins Nursing Evidence-Based Practice: Model and Guidelines (2nd ed). Indianapolis, IN: Sigma Theta Tau International.

Delany, C., Gillam, L., Spriggs, M., & Fry, C. (2010). The unique nature of clinical ethics in allied health paediatrics and child health. *Cambridge Quarterly of Healthcare Ethics, 19*, 471-480.

Eriksen, K. K. (2015). To know or not to know? Integrating ethical aspects of genomic healthcare in the education of health professionals. *Biochemistry and Molecular Biology Education, 43*(2), 81-87.

Ewashen, C., McInnis-Perry, G., & Murphy, N. (2013). Interprofessional collaboration-in-practice: The contested place of ethics. *Nursing Ethics, 20*(3), 325-335. doi:10.1177/0969733012462048

Fink, L.D. (2013). *Creating significant learning experiences: An integrated approach to designing college courses*. San Francisco, CA: Jossey-Bass.

Gabriele, E. F. (2011). Ethics leadership in research, healthcare and organizational systems: Commentary and critical reflections. *Journal of Research Administration, 42*(1), 88-102.

Goold, S. D., & Stern, D. T. (2006). Ethics and professionalism: What does a resident need to learn? *Am J Bioeth, 6*, 9-17.

Grisbrooke, J. (2013). Practising ethics: Bildungsroman and community of practice in occupational therapists' professional development. *Ethics and Education, 8*(3), 229-240.

Hanson, S. (2005). Teaching health care ethics: Why we should teach nursing and medical students together. *Nursing Ethics, 12*(2), 167-176.

Hardingham, L. B. (2004). Integrity and moral residue: Nurses as participants in a moral community. *Nurs Philos, 5*, 127-134.

Holmes, E. (2010). Character, leadership, and the healthcare professions. *Journal of Research Administration, 41*(2), 47-54.

IPEC. (2011). Core competencies for interprofessional collaborative practice. Retrieved from http://www.aacn.nche.edu/education-resources/IPECReport.pdf

Kalb, K. A. (2009). The three cs model: The context, content, and conduct of nursing education. *Nursing Education Perspectives, 30*(3), 176-180 5p.

Konishi, E., Yahiro, M., Nakajima, N., & Ono, M. (2009). The japanese value of harmony and nursing ethics. *Nursing Ethics, 16*(5), 625-636 12p. doi:10.1177/0969733009106654

Liaschenko, J., Oguz, N. Y., & Brunnquell, D. (2006). Critique of the "tragic case" method in ethics education. *Journal of Medical Ethics, 32*(11), 672-677.

Lin, Y., Chan, T., Lai, C., Chin, C., Chou, F., & Lin, H. (2013). The impact of an interprofessional problem-based learning curriculum of clinical ethics on medical and nursing students' attitudes and ability of interprofessional collaboration: A pilot study. *The Kaohsiung Journal of Medical Sciences, 29*(9), 505-511. doi:10.1016/j.kjms.2013.05.006

Loike, J. D., Rush, B. S., Schweber, A., & Fischbach, R. L. (2013). Lessons learned from undergraduate students in designing a science-based course in bioethics. *CBE - Life Sciences Education, 12*(4), 701-710.

Manson, H. M. (2012). The development of the CoRE-values framework as an aid to ethical decision-making. *Medical Teacher, 34*(4), e258-68 1p. doi:10.3109/0142159X.2012.660217

O'Donnell, L. (2007). Ethical dilemmas among nurses as they transition to hospital case management: Implications for organizational ethics, part II. *Prof Case Manag, 12*(4), 219-231.

Pask, E. (2005). Self sacrifice, self transcendence and nurses' professional self. *Nursing Philosophy, 6*(4), 247-254.

Pauls MA., & Ackroyd-Stolarz S. (2006). Identifying bioethics learning needs: A survey of canadian emergency medicine residents. *Society for Academic Emergency Medicine, 13*(6), 645-652. doi:10.1111/j.1553-2712.2006.tb01025.x

Pavlish, C., Brown-Saltzman, K., Jakel, P., & Rounkle, A. (2012). Nurses' responses to ethical challenges in oncology practice: An ethnographic study. *Clinical Journal of Oncology Nursing, 16*(6), 592-600 9p. doi:10.1188/12.CJON.592-600

Poikkeus, T., Numminen, O., Suhonen, R., & Leino-Kilpi, H. (2014). A mixed-method systematic review: Support for ethical competence of nurses. *Journal of Advanced Nursing, 70*(2), 256-271 16p. doi:10.1111/jan.12213

QSEN. (2012). Graduate-level QSEN competencies: Knowledge, skills, and attitudes. Retrieved from http://www.aacn.nche.edu/faculty/qsen/competencies.pdf

Rider, E. A., Kurtz, S., Slade, D., Longmaid, H. E., Ho, M., Pun, J. K., . . . Branch,William T.,,Jr. (2014). The international charter for human values in healthcare: An interprofessional

global collaboration to enhance values and communication in healthcare. *Patient Education and Counseling, 96*(3), 273-280. doi:10.1016/j.pec.2014.06.017

Sauerland, J., Marotta, K., Peinemann, M. A., Berndt, A., & Robichaux, C. (2014). Assessing and addressing moral distress and ethical climate, part 1. *Dimensions of Critical Care Nursing: DCCN, 33*(4), 234-245. doi:10.1097/DCC.0000000000000050

Sauter, M.K., Gillespie, N.N., Knepp, A. (2012). Educational program evaluation. In D. M. Billings & J. A. Halstead (Eds.). *Teaching in nursing: A guide for faculty* (4th ed., pp. 202-242). St. Louis, MO: Elsevier Saunders.

SCU. (2015). Retrieved from http://www.stkate.edu/schools/soh/mission.php

Solomon, P., & Geddes, E. L. (2009). An interprofessional e-learning module on health care ethics. *Journal of Interprofessional Care, ,* 1-4.

Stoddard, H. A., & Schonfeld, T. (2011). A comparison of student performance between two instructional delivery methods for a healthcare ethics course. *Cambridge Quarterly of Healthcare Ethics: CQ: The International Journal of Healthcare Ethics Committees, 20*(3), 493-501. doi:10.1017/S0963180111000181

Strawbridge, J. D., Barrett, A. M., & Barlow, J. W. (2014). Interprofessional ethics and professionalism debates: Findings from a study involving physiotherapy and pharmacy students. *Journal of Interprofessional Care, 28*(1), 64-65. doi:10.3109/13561820.2013.829423

Verkerk, M., Lindemann, H., Naeckelberghe, E., Feenstra, E., Hartoungh, R., & de Bree, M. (2004). Enhancing reflection: An interpersonal exercise in ethics education. *Hastings Center Report*, *34*(6), 31-38 8p.

Verma, S., Broers, T., Paterson, M., Schroder, C., Medves J.M., & Morrison C. (2009). Core competencies: The next generation, comparison of a common framework for multiple professions. *Journal of Allied Health*, *38*(1), 47-53.

Webb, S. A. (2006). Interprofessional education in health care. *Journal of the South Carolina Medical Association (1975)*, *102*(3), 70-73.

Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, *14*(3), 344-359.

Appendix A

Author(s)	Salient Findings	Level and Quality
Level III Articles		
Bosek, 2009	Identifies the ethical issues facing Registered Nurses (RNs) and analyzes the processes used by nurses to resolve ethical problems. Most ethical issues identified by nurses were regarding limiting treatment and relationship issues. Variable influencing nurse's ethical decision making include: communication (nurse/nurse, nurse/patient, nurse/doctor) and ethical environment. Education was the number 1 resource identified by nurses to assist them in resolving ethical issues.	Level III; Good Quality
Buelow, Mahan, & Garrity, 2010	Identifies ethical dilemmas faced by different health care disciplines. Effective strategies for teaching ethics include: short interactive sessions, small group discussions, student-led learning events, and clear, well-defined goals for each activity. The authors call for innovative learning strategies, like Interprofessional Education (IPE), to teach fundamental ethical ideas and provide a common language for understanding ethics. The top ethical issues identified by the healthcare students sampled were a) treating the uninsured or underinsured (*e.g.* omitting needed treatments), b) moral and religious dilemmas (*e.g.* end of life issues and abortion), and c) public policy not controlling the rising costs of healthcare (*e.g.* universal care concerns). Implications for education: 1) ethics courses must address student concerns so that they develop an ability to integrate ethical issues with their thinking and actions, 2) students must develop the ability to communicate and share with other health professionals so as to improve healthcare practice, and 3) traditional methods of delivering ethics education must be challenged and innovation embraced.	Level III; High Quality
Burkemper, Dubois, Lavin, Meyer, McSweeney	76% of Master's level nursing programs require ethics content. 21.4% require multidisciplinary ethics education. Nurse educators desire improvement in ethics education at the Master's level. Master's level nursing programs tend to focus on legal ethics and healthcare law while important clinical topics like end-of-	Level III; Good Quality

	life care and informed consents were addressed less frequently if at all. Medical schools establish achievement of outcomes by examination far more frequently than graduate level nursing courses. Master's nursing programs usually do not require instructors have additional training in ethics.	
Crisham, 1985	Nurses identified 4 underlying ethical issues in practice: 1) deciding the right to know and determining the right to decide, 2) defining and promoting quality of life, 3) maintaining personal and institutional standards, and 4) fairly distributing nursing resources. Teaching ethics to nurses should provide them with a ethical decision making process usable in practice. Courses should focus on finding a process for making ethical choices rather than finding a correct answer. Explicates the MORAL model for ethical decision making.	Level III; Good Quality
Goold & Stern, 2006	Study identifies ethical objectives for medical residents based upon qualitative analysis of interviews. Ethical issues important to residents and non-residents alike include: consent, interprofessional relationships, family interactions, communication skills, and end-of-life care. Non-medical residents identified formal ethics education, resources allocation, and self-monitoring as important ethical education issues. Residents identified resident/attending interaction and discordant formal and informal ethics curricula.	Level III; Good Quality
Lin, Chan, Lai, Chin, Chou, & Lin, 2013	Interprofessional problem based learning is well suited to ethics education. Describes an interprofessional, problem based learning clinical ethics course which consists of a 2 hour lecture and a 3 hour feedback session. Problem based learning tutorial were provided at the beginning of the course and at mid-course.	Level III; Good Quality
Loike, Rush, Schweber, & Fischbach, 2013	Describes 2 innovative science-based ethics courses offered to undergraduate students. The classes use a science based approach that meaningfully integrates science and ethics lending real-life utility to ethics education. Course is an elective with 15 lectures each 75 minutes long. The lectures examine current bioethical issues. The focus of the first lecture is on principalism, but the goal of the lectures is to foster critical thinking about ethics. Other ethical theories should be added to prevent indoctrination to the biomedical model Course goals include helping students identify ethical problems and devise their own decision making strategies using moral creativity and empirical knowledge as a guide.	Level III; Good Quality

	Students are assigned reading from primary ethics journals. They post responses to instructor posed questions by accessing an online discussion board. The final exam requires students to develop a logical, systematic approach to resolving an ethical dilemma and effectively communicate it to the instructor.	
Pauls, Ackroyd-Stolarz, 2006	Emergency room residents have specific bioethical learning needs best derived from learning assessment rather than expert opinion. Resident and nurses identified learning need themes include: end-of-life care, consent and capacity, truth telling and breaking bad news, confidentiality, relationships with patients and colleagues, learner-supervisor relationship, and resource allocation.	Level III; Good Quality
Pavlish, Brown-Saltzman, Jakel, & Rounkle, 2012	Nurse's response or inability to respond to ethical concerns leads to emotional distress and leaves moral residue. Study participant describe challenges to working in ethically difficult situations as having responsibility but limited power, having no voice in treatment decisions, balancing hope and honesty, and urgency in decision making. Nurses commented that ethics education improved their ability to participate in ethical decision making. Nurses report not understanding the biomedical model of ethical decision making, Providing interprofessional and collaborative learning events is needed.	Level III; Good Quality
Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014	Moral distress in nursing and other healthcare disciplines is increasing. Staffing and patient care issues such as futile care, environment of care, providers of care and their competency, and moral courage were identified by sample nurses as areas of moral distress.	Level III; Good Quality
Stoddard & Schonfeld, 2011	Identifies goals of healthcare ethics education as giving students the intellectual tools to recognize, analyze, and address ethical issues in practice and to create virtuous clinicians. Healthcare ethics education is well-suited to interprofessional education. Comparing two ethics classes, 1 online and 1 classroom, researchers found no difference in class participation and no difference in written assignment performance. The online cohort did, however, perform worse on multiple-choice questions at a statistically significant level. Constructed responses are recommended to test comprehension in ethics courses.	Level III; Good Quality

Strawbridge, Barrett, & Barlow, 2014	Interprofessional debate is a useful tool in teaching ethics and professionalism. Interprofessional debate promote a positive learning experience.	Level III; Good Quality
Zuzelo, 2007	Nurses are not prepared to manage everyday ethical issues in practice, and this lack of education causes moral distress. Areas identified as causing moral distress include: unsafe staffing, physician/colleague incompetence, ineffective pain control, and futile life sustaining treatments. Undergraduate and graduate school curricula should be assessed to ensure nurses are prepared to contribute to ethical decision making.	Level III; Good Quality
Level IV Articles		
Poikkeus, Numminen, Suhonen, Leino-Kilpi, 2013	Ethics education is a research based strategy for supporting ethical competence in nurses. Multidisciplinary environments support ethical competence in nurses. Critical reflection and moral creativity are important in resolving ethical problems.	Level IV; High Quality
Rider et al., 2014	There are fundamental and universal values that underpin healthcare interactions. These values are delineated by *The International Charter for Human Values in Healthcare*. They include: commitment to integrity and ethical practice. Sub-values include: commitment to honesty and trustworthiness, reliability, accountability, commitment to do no harm and the patient's well-being as well as non-judgmental care.	Level IV; High Quality
Level V Articles		
Angel & Simpson, 2007	Explores the efficacy of delivering integrated pharmacy ethics education through the development of an ethics manual that covers 9 foundational content areas followed by practical application of ethical principles. Advocates principalism as a conceptual basis for bioethical education. Proposes learning objectives and outcomes consistent with an integrated ethics curriculum. Proposes teaching and learning strategies based upon information processing theory.	Level V; High Quality
Bolsin, Faunce, & Oakley, 2005	Concedes that the biomedical model is preeminent in medical school curricula, but advocates teaching professional virtues. The authors argue that virtue ethics better prepares healthcare professionals to act with integrity and expose unethical practices or wrongdoing. Advocates use of technology like Personal Digital Assistants (PDAs) to expedite reporting and monitoring of adverse	Level V; High Quality

	events. The authors suggest that connecting professional virtue to "whistle-blowing" in the clinical world will lead to more ethical and virtuous professionals and a more ethical health care culture.	
Bolton, 2015	Narrative writing and discussion of literature leads to critical reflection and development of more ethical and virtuous practices.	Level V; High Quality
Brazg, Dotolo, & Blacksher, 2014	Social Workers are often excluded from the ethical decision making process. Argue that purposeful inclusion of Social Workers on hospital ethics committees would improve patient experiences. Social Workers are trained to use a "strengths based" approach to client assessment which could add to how ethics committees view quality of life and interpret patient perspectives. Social workers are not well trained in ethical theory, but they offer field experience in bioethics application.	Level V; High Quality
Callahan, 1973	Bioethics as a discipline must help health and scientific professionals make choices that impact lives. Moral choices must be right rather than wrong. Bioethics must be relevant to practice. Moral decisions should be arrived at in a systematic and rigorous fashion.	Level V; High Quality
Catlin, 2014	Hospital ethics committee use knowledge of moral reasoning, individual cultural values, knowledge of law, and understanding of ethics. Nurses serving on ethics committees can make substantial contributions to the respect other professionals have for nursing as a profession. Masters prepared nurses should be prepared to contribute to ethics committees.	Level V; Good Quality
Cellucci, Layman, Campbell, & Zeng, 2011	Information Systems (IS) professionals may serve on ethics committees and provide unique insights into bioethics. Bioethics courses often teach a verbal "shorthand" not understood by non-healthcare professionals. To contribute to ethical decision making in practice, one must learn the language of bioethics (*i.e.* the tenets of ethical principalism).	Level V; Good Quality
Cruess, Johnston, & Cruess, 2002	There is a social compact between professionals and society where professionals are allowed to practice and gain the rewards of that practice, but they must guarantee adherence to professional virtues. Professionalism requires the embodiment of ethical values such as service and altruism. Professionals must be explicitly taught because those serving in a professional capacity require knowledge of the values they must uphold.	Level V; Good Quality

Dahnke, 2014	Healthcare ethics is usually taught in a top-down approach that begins with principles and theory and works down toward concrete application. Theories taught in healthcare ethics include Kantian deontology, utilitarianism, virtue ethics, feminist ethics (e.g. ethics of care) and principalism. Describes a "bottom-up" methodology. Delineates key criticisms of ethical codes including: "the interpretation problem, the multiplicity problem, the legalization problem, and the futility problem." Teaching ethics using ethical codes can be accomplished if the "what, where, why, and when" of the code are explored. In other words, why the code has moral authority and how the code is properly applied must be explored if codes are used in ethical education. Ethical codes can be useful in theory application.	Level V; High Quality
Delany, Spriggs, Fry, & Gillam, 2010	Identifies trends in healthcare ethics education including ethical decision making, virtue ethics, health advocacy, moral agency, and professionalism. Ethics education in allied health should from everyday ethical issues faced by healthcare professionals. Ethics education that explores moral agency, questioning of personal values, and practical concerns is relevant to allied health professionals. Ethics education is challenging because of the various levels of understanding between disciplines. There are 3 areas relevant to pediatric allied health professional's ethics education: 1) relationship building, 2) negotiating with patient, family, and other professionals, and 3) understanding their role in ethical discourse and decision making. In pediatric allied health, moral stress arises from balancing and negotiating professional autonomy with the interests of other stakeholders. For allied health professionals, actively participating in ethical discussion and decision making is a worthwhile educational endeavor. Ethics education needs to focus on clinically relevant issues and practice concerns.	Level V; High Quality
Eriksen, 2015	Reflectivity is a key component of ethics education. Reflective professionals must, not only reflect upon their practices, but act to change them for the better. Students must have contextual awareness in ethics education and be aware of contextual gaps in their curricula.	Level V; High Quality

	Using “anchored ethical dialog” whereby instruction is designed to develop reflectivity using planned points in student ethical dialog where the dialog is actively linked to concrete base in student learning. Describes case-based ethical instruction for internal ethics learning. Using anchored ethical dialog in an IPE environment may establish better connections between classroom and real-life.	
Ewashen, Mcinnis-Perry, & Murphy, 2013	Propose that different ethical perspectives are imperative for collaborative ethical decision making because each discipline makes a unique contribution to the collaboration. Role understanding and communication are essential for effective collaborative practice. Identifies challenges to interprofessional ethical decision making including commitment to interprofessional dialog, removing personal and institutional barriers to interprofessional decision making, and valuing new ethical perspectives. Principalism, relational ethics, and virtue ethics are applies to clinical scenarios.	Level V; Good Quality
Gabriele, 2011	“Top-down” ethics education is counter to natural human learning. Professionals and organizations must know their own values and characters to serve others. Ethical challenges of lexification, viewing ethics as strict oversimplification of law, reification or viewing ethics as a simple thing instead of a dynamic course of inquiry, and deification which is the tendency to believe that ethical knowledge is possessed by a few and others should defer to their perspectives. The Carnegie Foundation’s directives on ethics education calls for deeper ethical understanding than mere observance of professional codes which is derived from virtue based ethics.	Level V; High Quality
Hanson, 2005	Reports on a 1 semester course taking by medical and nursing students. Lecture style course followed by a small-group work component. Concludes that healthcare ethics is appropriate for interprofessional education and can even be a better way to teach bioethics. Recommends the use of an interdisciplinary text rather that a discipline specific textbook. Recommends using team teaching approach with instructors from varied backgrounds. Must consider course scheduling and room assignments, but the cost of implementation can be absorbed by multiple	Level V; High Quality

	departments.	
Hardingham, 2004	Defines bioethics as a critical reflection on moral and ethical problems encountered in healthcare. Bioethics includes deciding what is morally right, explaining why an action is morally correct, and providing a method to implement the decision. Moral integrity is integral to healthcare ethics. Developing moral integrity is a relational process where nurses reflect upon their own values and actions while engaging in dialog with other professionals. Nurses face ethical issues that are practical and systematic. Advocates a shift from individual decision making in ethics to relational decision making.	Level V; High Quality
Holmes, 2010	Lecture explaining the ethics education for midshipmen at the United States Military Academy. Students use an interactive video simulation to learn ethics and leadership. Delineates a practical tool for ethical decision making. Advocates a 4 part system for moral decision making that includes assessing moral awareness, moral judgement, moral intention, and moral action.	Level V; Good Quality
Konishi, Yahiro, Nakajima, & Ono, 2009	Many Japanese nurses find Western ethics abstract with little connection to real-world practice. In Japan, self is viewed as part of a relationship with others and society. Finding harmony between the wants and needs of the individual and those of others is essential to good ethical outcomes in Japan's culture. In Japan, teaching ethics using case studies and student writing assignments is successful.	Level V; High Quality
Liaschenko, Oguz, & Brunnquell, 2006	The "tragic case" method of ethics education where students are provided a challenging ethical dilemma with high stakes outcomes and asked to resolve the problem, fails to provide health professionals a means of dealing with everyday ethical issues. Principle based ethics is prone to oversimplification and neglects professional judgement. Rather than focusing on tragic cases, suggests viewing ethics as a part of every relationship the healthcare professional develops. Pedagogically, students must be taught the intrinsic importance of relationships in healthcare. Focus should be on the intricacies of the patient-provider/colleague/institutional/societal relationship and on the professional as moral agent. Classroom ethics education should begin with identifying	Level V; High Quality

	student moral concerns and subsequent analysis. Instructors should aim to inspire moral creativity in their students.	
Manson, 2012	Medical schools commonly teach ethical dilemma resolution tools to teach ethics. Most ethical tools are based upon principalism, but they lack scientific rigor. Summarizes the common ethical tools currently encountered in healthcare. Identify deficiencies in available ethical tools such as a lack of contextual awareness or a disregard for legal ramifications. Ethical tools either oversimplify problems or, conversely, become too complex to be usable in clinical practice. Based upon available evidence, the authors developed the CoRE Values tool: Co – Codes of professional practice R - Regulations E - Ethical Principles Values – personal beliefs/ideologies of stakeholders.	Level V; High Quality
O'Donnell, 2007	Describes ethical concerns as themes encountered by nurses transitioning to the case management role. Themes include case management as a balancing act, framing contentious options, speaking for vulnerable individuals, and having responsibility without power. Recommends that nursing curricula cover ethics, ethical decision making, organizational ethics, and conflict resolution. Recommends teaching ethics interprofessionally (between nursing and physicians).	
Pask, 2005	Professionalism in nursing requires the ability to act on moral convictions as a part of the compact between professional and society. Nurses face many constraints in practice that impedes their ability to act upon their moral convictions. Having the courage to face constraint requires knowledge of self as well as social support. Knowing self stems from conscious reflection as well as reflection with others. Concern for others and understanding inner values allows nurses to transcend barriers to moral action.	Level V; High Quality
Soloman & Geddes	Describes a process for using problem based e-learning modules to deliver interprofessional ethics education. Students were able to learn about each other's professional roles and scope of practice in an online asynchronous environment.	Level V; Good Quality
Verkerk,	Professionals must have the ability to reflect critically to be	Level V;

Lindemann, Maeckelberghe, Feenstra, Hartoungh, & DeBree	able to do the right thing. Morality is relational and intrinsically interpersonal. Moral competency requires developing a skill set that allows professionals to see what is morally relevant in any given situation. Professionals must develop skills to shape the moral narrative and, through reflection, understand different perspectives. Describe a 3 part tool that aids the professional in shaping moral issues so that they are understandable and actionable.	High Quality
Webb, 2006	Bioethics crosses disciplines and ought to be taught in an IPE format.	Level V; Good Quality

Appendix B

Core Competencies across Disciplines

Nursing	**QSEN (2012)** *Quality* • Analyze ethical issues associated with continuous quality improvement • Participate in the design and monitoring of ethical oversight of continuous quality improvement projects • Maintain confidentiality of any patient information used in quality improvement efforts • Value ethical conduct in quality improvement efforts Value the roles of others, such as IRBs, in assessing ethical and patient rights/informed decision making *Team Work and Collaboration* • Analyze self and other team members' strengths, limitations, and values • Demonstrate awareness of personal strengths and limitations as well as those of team members • Value the contributions of self and others to effective team function *Patient Centered Care* • Analyze ethical and legal implications of patient-centered care	**IPEC (2011)** VE1. Place the interests of patients and populations at the center of interprofessional health care delivery. VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care. VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.

	• Work to address ethical and legal issues related to patients' rights to determine their care • Respect that legal and ethical issues provide a framework for patient-centered care **AACN (2011) Master's Essentials** *Essential VII*: Interprofessional Collaboration for Improving Patient and Population Health Outcomes Essential IX: Master's-Level *Nursing Practice*: #8 Incorporate core scientific and ethical principles in identifying potential and actual ethical issues arising from practice, including the use of technologies, and in assisting patients and other healthcare providers to address such issues.	VE4. Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions. VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.
Physical Therapy	**CAPTE (2015)** 6F: The didactic and clinical curriculum includes interprofessional education; learning activities are directed toward the development of interprofessional competencies including, but not limited to, values/ethics, communication, professional roles and responsibilities, and teamwork.	VE6. Develop a trusting relationship with patients, families, and other team members.

	7D6: Implement, in response to an ethical situation, a plan of action that demonstrates sound moral reasoning congruent with core professional ethics and values.	VE7. Demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care.
Physician Assistant	**ARC-PA (2010)** 1.08: The curriculum must include instruction to prepare students to work collaboratively in interprofessional patient centered teams. B2.16: The program curriculum must include instruction in the principles and practice of medical ethics.	
Social Work	**CSWE (2010)** Educational Policy 2.1.2: Apply social work ethical principles to guide professional practice. Social workers have an obligation to conduct themselves ethically and to engage in ethical decision-making. Social workers are knowledgeable about the value base of the profession, its ethical standards, and relevant law. Social workers recognize and manage personal values in a way that allows professional values to guide practice; make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics and, as applicable, of the International Federation of Social	VE8. Manage ethical dilemmas specific to interprofessional patient/population centered care situations.

	Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles; tolerate ambiguity in resolving ethical conflicts; and apply strategies of ethical reasoning to arrive at principled decisions. On 10/23/2014 CSWE Board of Directors unanimously endorsed IPEC principles (CSWE, 2015).	VE9. Act with honesty and integrity in relationships with patients, families, and other team members.
Occupational Therapy	**AOTA (2012)** B.9.1: Demonstrate a knowledge and understanding of the American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics, Core Values and Attitudes of Occupational Therapy Practice, and AOTA Standards of Practice and use them as a guide for ethical decision making in professional interactions, client interventions, and employment settings. B.5.21: Effectively communicate, coordinate, and work interprofessionally with those who provide services to individuals, organizations, and/or populations in order to clarify each member's responsibility in executing components of an intervention plan	VE10. Maintain competence in one's own profession appropriate to scope of practice.

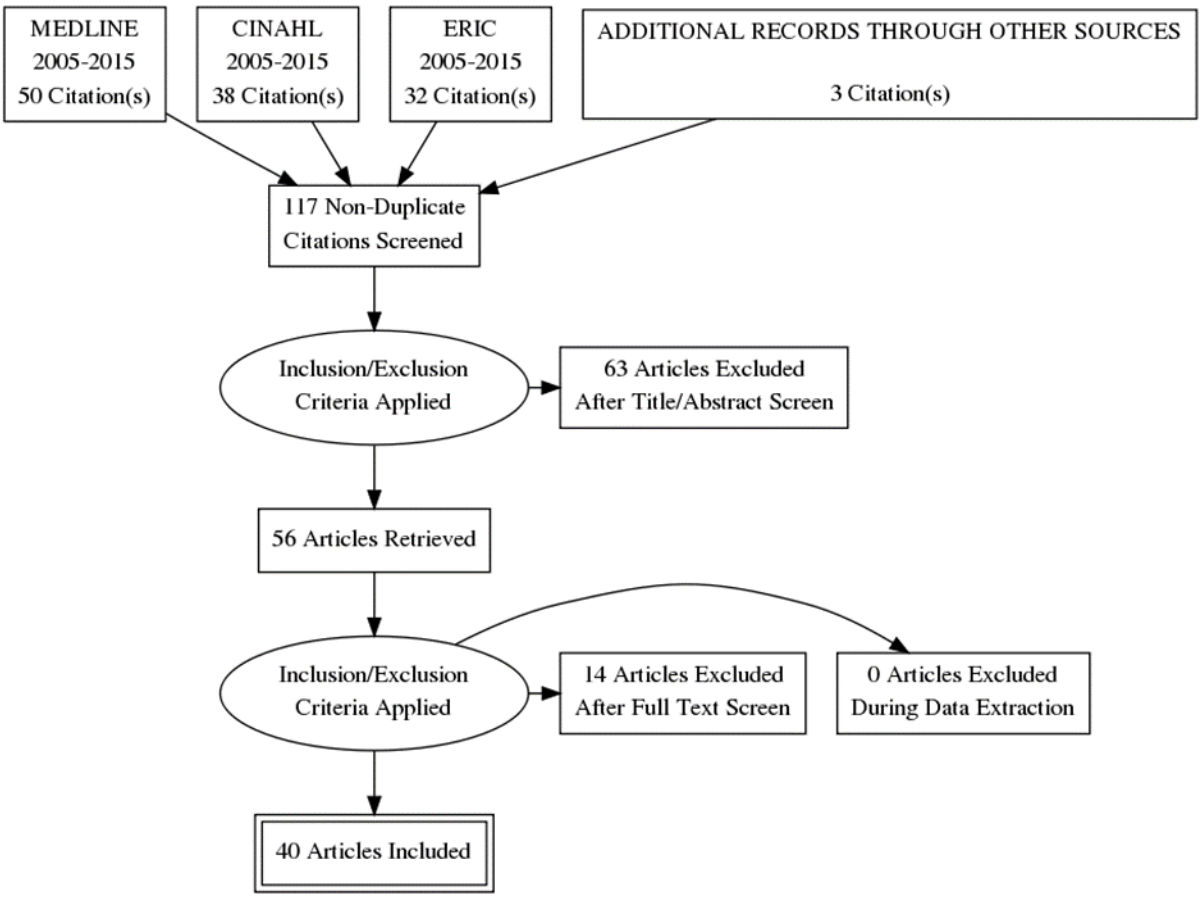

Figure 1. Flowchart depicting the systematic literature review conducted in this study.