<Original Article>

Certified Nurse Specialists' Ethical Practices in Critical Care Nursing

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ABSTRACT

Objective: This study explored how ethically certified nurse specialists in critical care nursing (CCNS) practice in the critical care setting.
Methods: Focus group interviews (FGI) were conducted with 11 CCNS' who had successfully renewed their CCNS certification at least once, a process which is required every five years, and were working in critical care. Data were analyzed using a qualitative synthesis method (KJ method).
Results: Ethical practice has six characteristics: [awareness as the CCNS responsible for patients' lives], [emphasis on a patient-centered perspective], [facilitation of consensus-building among healthcare professionals in the face of changing patient conditions and time-constrained situations], [addressing conflicts in perceptions, thoughts, and approaches between patients/families and healthcare professionals], [efforts to foster an ethical organizational climate], and [initiatives to engage the organization in ethical practices].
Conclusion: Based on their personal sense of ethics, CCNS' demonstrated three patient- and family-oriented, and two organizationally focused ethical practices

INTRODUCTION

The ability to handle life-threatening situations arising from sudden and severe symptoms or trauma is essential in critical care. Nurses encounter various ethical dilemmas in their work environment as the medical field evolves rapidly and healthcare settings continually change, with patients and families from diverse backgrounds. Ethical dilemmas in critical care often involve end-of-life and palliative care, decisions about treatment options, and choices regarding life-prolonging treatments or treatment discontinuation made by family members on behalf of patients. Critical care nurses may experience conflict or distress as they face and navigate these issues daily.

Although nurses in critical care are expected to provide holistic care and adhere to a code of ethics, there are instances where the care provided falls short due to the complexity and rapid advancement of clinical treatments [1]. Previous studies indicate that nurses working in emergency resuscitation and life-prolonging treatment consistently strive to ensure patients and their families receive the highest level of care despite these ethical challenges [2]. In this unpredictable medical environment, critical care nurses must continually seek solutions to the ethical challenges and dilemmas they encounter while striving to deliver high-quality care to patients and their families. However, these

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challenges are diverse and often require time to resolve, with individual efforts frequently proving insufficient.

Certification for critical care nursing specialists (CCNS) in Japan began in 2005. These specialists address the various challenges and ethical dilemmas that arise within the critical care nursing field. CCNS provide intensive care to patients requiring emergency or critical care while supporting both the patients and their families. Additionally, they are expected to collaborate with and support other members of the medical team to ensure the delivery of the highest quality care [3].

Research on the ethical practices of CCNS includes studies on their ability to coordinate ethically with patients receiving end-of-life care in the ICU and with young patients suffering from terminal heart failure due to dilated cardiomyopathy [4, 5]. These studies show that CCNS possess the skills and approaches necessary to practice ethically while also providing support, building rapport, and respecting the dignity and rights of patients and their families. However, no research has examined the holistic structures underlying ethical practice within the critical care field.

The ability to practice ethically while providing care in the unpredictable critical care environment is required not only of CCNS but of all nurses. Ethical practice is thus a desirable trait for individuals in the nursing profession. The researchers believe that exploring the abilities of CCNS in ethical practices can inform efforts to train nurses in ethical practice. Furthermore, such insights can provide nurses with a foundation for reflecting on their actions. This is expected to aid nurses in gaining the knowledge necessary to develop ethical practices, improve the quality of care, and contribute to the advancement of nursing ethics in critical care.

This study aims to explore the thought and decision-making processes that inform the ethical practices of certified critical care nursing specialists within the critical care field.

RESEARCH METHODS

Definition of terms used in this paper

The term *ethical practice* refers to the thought processes and actions of CCNS as they strive to provide the highest quality care to patients while respecting their rights and dignity in ethically challenging situations.

Research design

A qualitative induction design was chosen to explore the logical structures underlying the application of ethical practices in clinical settings by CCNS, who face various ethically challenging scenarios.

Participants

Potential participants were selected from the pool of certified CCNS by the Japanese Nursing Association, a public interest incorporated association. In addition to holding critical care certification, participants were assessed based on the following criteria during the selection process: (1) whether they had passed the CNS recertification exam, held every five years, at least once; and (2) whether they were working in the critical care field at the time of the study. Nurses meeting all these criteria were shortlisted as potential participants.

The researchers contacted the institutions affiliated with these nurses to request permission for recruitment. Where permission was granted, the shortlisted CCNS were briefed on the study's aims, either verbally or via email. CCNS who agreed to participate were recruited as the final participants.

Period during which this study was conducted

This study was conducted from November 2020 to January 2023.

Data collection

Focus group interviews (FGIs) were chosen for their ability to gather rich data on group dynamics among participants. Eleven participants were divided into three groups, in terms of years of experience, areas of affiliation, etc. Group One was interviewed in person, whereas Groups Two and Three were interviewed online due to the inability to conduct in-person interviews during the COVID-19 pandemic. Each group participated in a single 90-minute session. Groups consisted of three to four participants.

Participants were asked to freely discuss memorable experiences from their ethical practices in critical care, as well as facts related to ethical practice or its history. Permission to record the interviews was obtained from all participants.

Data analysis

The content of the interviews was transcribed verbatim before being organized. Qualitative analysis was performed according to the qualitative synthesis method (KJ method). The qualitative synthesis method originally developed by Kawakita was adopted in this study [6–10]. Kawakita explains that this method of analysis is suitable for identifying a rational framework and order from complicated and diverse contents of phenomena. The steps taken during data analysis are outlined below:

1. Label creation

The transcripts from all participant groups were analyzed to identify phrases related to ethical practices of CCNS. Each phrase was treated as a singular unit, which was used to create units of data (hereafter referred to as pre-labels). Each pre-label was designed so that a single label represented one unit of meaning.

2. Multi-step pickup method

The multi-step pickup method, a key feature of the KJ method [11], was used to ensure that each piece of gathered

data was utilized to its fullest value. The pre-labels created from the transcripts were scrutinized, and the most crucial ones were selected. To ensure diversity and avoid bias in the selected content, four researchers familiar with the study's aims collaborated to repeat this process in stages until no further labels could be extracted. All four researchers were trained in conducting qualitative research using the qualitative synthesis method (KJ method). The target number of final labels was set at 100–150, as stated by Yamaura [8].

3. Categorizing labels into groups

The labels extracted using the multi-step pickup method were spread out, and each was read aloud two to three times. Labels were then categorized into groups based on similarities in meaning. New titles (or labels) that concisely conveyed the essence of each group were created after grouping. This process was repeated until the number of groups was five to seven.

4. Structural organization (spatial arrangement) of data and symbol creation

The grouped data were spatially arranged to make the relationship structures between groups visually identifiable. Researchers added notes and symbols to illustrate these relationships and form a narrative. Symbols summarizing each group's contents concisely were added to the structural representation, with each symbol representing two units of meaning in the format: [phenomenon: essence].

Maintaining data reliability and validity

The analysis in this study was carried out by four researchers, who specialize in critical care nursing. They are experienced in qualitative research and received multiple training sessions in applying the qualitative synthesis method (KJ method). The spatial arrangement diagram of data units was developed under the guidance of a research instructor in the KJ method to ensure data reliability and validity.

Ethical considerations

This study was conducted following review and approval by the Ethics Review Committee at Kansai Medical University (approval code 2019264). Approval was also obtained from the authorities at the institutions affiliated with the participants. Participants were briefed verbally and in writing on the study's objectives, their right to refuse participation, and how their personal information would be kept confidential. Consent was obtained through signed consent forms from participants who agreed to take part in the study.

RESULTS

Summary of participants

The participants were 11 women in their 40s and 50s, with 17 to 33 years of nursing experience and 8 to 15 years of experience working as CCNS. Participants worked in intensive care units, critical care centers, surgical wards, or the nursing department. Two participants were solely appointed as CCNS, while the other nine also held additional roles, such as staff nurse, supervisor, head nurse, assistant head nurse, or deputy director. The focus group interviews lasted 75–90 minutes (**Table 1**).

Results from data analysis

During the first stage of data analysis, 239 pre-labels were created. After four applications of the multi-stage pickup method, 134 of the pre-labels were selected for fur-

Table 1 Overview of participants

ID	Sex	Age	Years of nursing experience	Years of CCNS experience	Position/Role	Department
A	F	50's	33	12	deputy director	Nursing department
B	F	50's	28	10	head nurse	Emergency and critical care centers
C	F	40's	26	8	head nurse	Surgical wards
D	F	40's	17	9	assistant head nurse	ICU
E	F	40's	28	8	head nurse	ICU
F	F	40's	26	15	supervisor	Nursing department
G	F	50's	28	15	head nurse	ICU
H	F	40's	24	14	head nurse	NICU/GCU
I	F	40's	27	12	assistant head nurse	Emergency and critical care centers
J	F	40's	25	10	staff nurse	ICU
K	F	40's	25	14	assistant head nurse	Nursing department

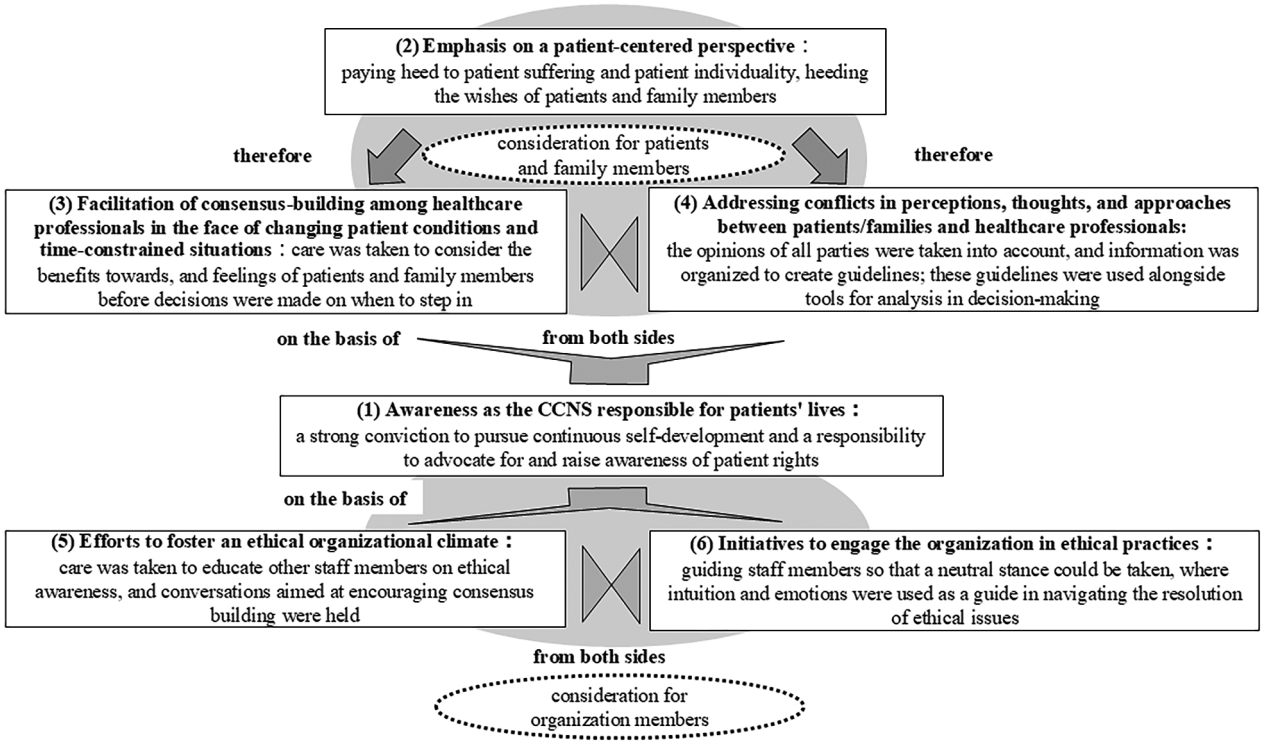

Figure 1 Certified Nurse Specialists' Ethical Practices in Critical Care Nursing

ther use. The discarded labels were then reviewed again, resulting in a total of 153 labels being chosen for subsequent stages. After eight rounds of data categorization, the selected labels were consolidated into six groups.

The structural organization of the data following analysis is shown in Diagram 1. The numbers (1) through (6) in Diagram 1 correspond to the symbol markers used.

1. The overview of ethical practices of CCNS

The analysis revealed that CCNS relied on their own sense of ethics as a foundation for their practice and actions (**Figure 1**). Furthermore, participants identified three points of action related to patients and their families and two points of action related to other staff members in their workplace.

Firstly, participants demonstrated an (1) [awareness as the CCNS responsible for patients' lives: a strong conviction to pursue continuous self-development and a responsibility to advocate for and raise awareness of patient rights]. This served as the foundation for participants' decision-making and actions as they strived to practice ethically from two perspectives.

The first perspective involved ethical practice that considered patients and their families. Participants emphasized (2) [emphasis on a patient-centered perspective: recognizing patient suffering and individuality, and respecting the wishes of patients and their family members]. This focus guided participants to practice ethically in the following two ways when addressing the needs of patients and their families.

Participants demonstrated ethical practice through various actions directed at patients, families, and other staff members. First, they facilitated (3) [facilitation of consensus-building among healthcare professionals in the face of changing patient conditions and time-constrained situations], ensuring decisions considered the benefits to and feelings of patients and families before intervening. They also addressed (4) [addressing conflicts in perceptions, thoughts, and approaches between patients/families and healthcare professionals], taking all opinions into account, organizing information into guidelines, and using analytical tools to support decision-making. In their workplace, participants fostered (5) [efforts to an ethical organizational climate] by educating staff on ethical awareness and encouraging consensus-building through discussions. Additionally, they engaged (6) [initiatives to engage the organization in ethical practices] by guiding staff to adopt a neutral stance, where intuition and emotions aided in resolving ethical issues. By leveraging the power of their affiliated institutions and incorporating these approaches, participants effectively addressed the needs of patients, families, and colleagues, exemplifying ethical practice in critical care.

The contents of each symbol marker will be illustrated in the following section, incorporating both the final group titles and pre-label units. The contents of the symbol markers will be presented within square brackets, following the structure [phenomenon: essence]. Text in **bold and *italics***

represents groups formed during data analysis, while the titles of pre-labels are enclosed in single quotes.

2. Contents of symbol markers

1) [Awareness as the CCNS responsible for patients' lives: a strong conviction to continue self-development and a responsibility to advocate for, and raise awareness of patient rights]

This group of data was ***a strong conviction that self-development, as well as a resolve and sense of responsibility to put one's foot down for the sake of patients and family members is necessary for those who are responsible for patients' lives, as well as advocating for and raising awareness of patients' and family members' rights, so that one can stay calm and unbiased even in times of crisis***.

The pre-labels that encompassed this set of data, before analysis, comprised of (but is not limited to) the following:

- 'I think that our job is protecting the rights of patients. It's not just a responsibility but also a conviction we should have. We want to support patients so that we can provide them with the best care possible.'
- 'I think it's a sense of responsibility. The crux of nursing jobs is how we're responsible for the lives of patients, and we need to understand that. We need to be prepared to support them in their lives, and that requires a sense of responsibility and a strong resolve, in my opinion. I'm always unsure of how to shape that resolve and sense of responsibility.'

2) [Emphasis on a patient-centered perspective: paying heed to patient suffering and patient individuality, heeding the wishes of patients and family members]

This group of data was ***even though decisions tend to be made following the decisions of medical staff in the critical care sector, it is thought that treatment and care that takes into account the patients' previous lifestyle, experiences and individuality that is also accepted by the patient and their family members, as well as a point of view that considers the patient and whatever pain they may be experiencing due to their condition, form the foundation of ethical practice***.

The pre-labels that encompassed this set of data, before analysis, comprised of (but is not limited to) the following:

- 'Us nurses tend to have a lot of say in what pace we should be handling things at in the ICU; even if it's just one form of care we provide for our patients, we try to fit that into one part of our schedule so that we can take care of it, but I think we should try to think more from the perspective of the patients. Is that care we're providing really something that they want? Is it something that will help them be more comfortable during their stay, or help them recover more comfortably?'
- 'I always try to keep in mind what the patient is thinking: are they suffering, or is it tough for them at the time? I think the time I spend trying to figure that out is much longer (compared to when I was just a staff member).'

3) [Facilitation of consensus-building among healthcare professionals in the face of changing patient conditions and time-constrained situations: care was taken to consider the benefits towards, and feelings of patients and family members before decisions were made on when to step in]

This group of data was ***making decisions on when to step in so that medical staff can form a consensus on medical treatment provided according to prognoses that are based on medical rationale, while taking into account patients' wishes, interests and individuality within the constraints of time and changing patient conditions while also being considerate of family members who are faced the burden of with having to make decisions that affect patients' lives***.

The pre-labels that encompassed this set of data, before analysis, comprised of (but is not limited to) the following:

- 'When we try to figure out what's the problem, we need to discuss with other medical staff members and come to a consensus based on medical rationale. That's what I think, so I decided that I would act accordingly at conferences.'
- 'We can make irreversible mistakes if we get the timing wrong; we work in the critical care sector where our patients have serious and sudden onsets of symptoms. Our decisions really will have a bearing on their lives, so I feel that I always have this sense of danger, something like, if I don't share this here, things might take a turn for the worse and take an irreversible turn.'

4) [Addressing conflicts in perceptions, thoughts, and approaches between patients/families and healthcare professionals: the opinions of all parties were taken into account, and information was organized to create guidelines; these guidelines were used alongside tools for analysis in decision-making]

This group of data was ***whenever there were discrepancies between medical staff and patients or family members, regarding personal opinions, patient condition, or the treatment or care provided, efforts would be made to gather information and opinions from other medical staff; guidelines and tools were also used for analysis, because it was understood that differences in opinion, or differences in viewing the patients' current situation between medical staff and patients/families are always possible, and that there is a tendency for medical staff tend to have a greater influence than patients or families***.

The pre-labels that formed this group before analysis included, but were not limited to, the following:

- 'I always try to make clear the reasons (behind differences in opinions of medical staff and family members regarding a patient's condition), and I try to take an approach that bridges the gap between both sides. I

think there's a need for us to think of what can be done.'

- 'When we as medical staff feel this sense of unease, it's very unspecific. I use tools like the Four Topics Approach to help make clear where exactly the problem lies, and then palliative care nurses can work together with staff members to find out where the problem lies and deal with it in supporting patients; I have intervened like that before as a CNS.'

5) [Efforts to foster an ethical organizational climate: care was taken to educate other staff members on ethical awareness, and conversations aimed at encouraging consensus building were held]

This group of data was ***being involved in the education of other nurses so as to raise their awareness of ethics, working together with those in supervisory roles to spread information on the importance of ethics of care, as well as patient prognoses, while working in an environment where individuals have different cultural backgrounds and responsibilities, where employees have various roles and unspoken knowledge is commonplace; taking efforts to enforce ethical practice through creating an ethical organizational climate where honest communication between individual staff members is possible in the best interest of patients***.

The pre-labels that encompassed this set of data, before analysis, comprised (but is not limited to) the following:

- 'I think it's important to also be there with other staff members, and focus on what we notice. Or it could be something that's happened, and we wonder what it is exactly – to raise their awareness of ethical issues, it's important to be there together and experience the same things together while we look at things that happen from the same point of view, I think.'

6) [Initiatives to engage the organization in ethical practices: guiding staff members so that a neutral stance could be taken, where intuition and emotions were used as a guide in navigating the resolution of ethical issues]

This group of data was ***being able to catch on to ethical issues at an early stage while taking an impartial stance, taking care to respect all involved parties while also involving relevant organizations or authorities when stepping in, picking up (emotionally or intuitively) on times when treatment or care may stop or undergo changes using information from prognoses; having a resolve and strong will to tackle ethical challenges, while working in institutions where the Japanese cultural values of being modest and not overly asserting oneself are prevalent***.

The pre-labels that encompassed this set of data, before analysis, comprised (but is not limited to) the following:

- 'I think that periods when care or treatment methods start to slow down are things that CNS are able to catch on to while they stay impartial.'
- 'It's very difficult to have discussions when an outsider is there, so I make sure to introduce myself and make sure I'm not coming across as overbearing or intimidating. I try to start with creating an environment where patients know I'm there to listen to what they have to say when I first step in. I think it goes without saying that this is so important.'

DISCUSSION

In this section we will discuss actions taken towards ethical practice, as well as how to implement these actions in the nursing field moving forward.

1. Actions taken by CCNS in striving to practice ethically, based on a personal sense of responsibility and personal convictions

1) Ethical practice that takes into account patients and family members

It was found that three actions were taken when considering patients and their families: participants placed (2) [emphasis on a patient-centered perspective: paying heed to patient suffering and patient individuality, heeding the wishes of patients and family members]. There was (3) [facilitation of consensus-building among healthcare professionals in the face of changing patient conditions and time-constrained situations: care was taken to consider the benefits to and feelings of patients and family members before decisions were made about when to intervene], and (4) care was taken to [addressing conflicts in perceptions, thoughts, and approaches between patients/families and healthcare professionals: the opinions of all parties were taken into account, and information was organized to create guidelines; these guidelines were used alongside tools for analysis in decision-making].

In relation to placing (2) [emphasis on a patient-centered perspective: paying heed to patient suffering and patient individuality, heeding the wishes of patients and family members], participants described how they worked with medical professionals to determine the wishes of family members making decisions on the patient's behalf and consistently considered the pain experienced by patients during treatment. The time and effort required to address ethical issues tend to increase with the complexity and challenging nature of these issues. However, understanding and respecting the patient's wishes remain of utmost importance when ethical dilemmas arise [12]. It has been reported that CCNS working in intensive care units can perform ethical coordination and take actions to reduce patient suffering to the best of their ability without giving up, even in situations where understanding the patient's wishes is difficult [4]. Similarly, this study found that participants made significant efforts to accurately understand the suffering experienced by patients and demonstrated respect for patients as living individuals.

The CCNS who participated in this study emphasized

the importance of viewing issues from the patient's perspective while maintaining ethical considerations in their daily practice at work. While prioritizing the patient's perspective, participants also (3) [facilitation of consensus-building among healthcare professionals in the face of changing patient conditions and time-constrained situations: care was taken to consider the benefits to and feelings of patients and family members before decisions were made about when to intervene].

Patient conditions constantly change within the critical care sector, where time constraints are common. In such situations, family members may need to make decisions on the patient's behalf, often experiencing a state of crisis accompanied by significant emotional distress [13]. Participants recognized the burden placed on family members in these scenarios and believed that consensus formation among medical professionals regarding appropriate care and treatment methods was crucial. They were, therefore, deliberate in deciding when to intervene.

Participants were also (4) [addressing conflicts in perceptions, thoughts, and approaches between patients/families and healthcare professionals: the opinions of all parties were taken into account, and information was organized to create guidelines; these guidelines were used alongside tools for analysis in decision-making]. Despite their extensive knowledge as CCNS, participants did not rely solely on their experience. Instead, they used guidelines and tools informed by prior research evidence, demonstrating a deep understanding of the concepts and ideologies underpinning these tools and guidelines.

The high-quality care provided by CCNS, who possess extensive knowledge and experience, underscores the importance and necessity of providing specialist education for nurses at the postgraduate level.

2) Ethical practice that takes into account the organization

Participants were found to take two key courses of action that considered other staff members while striving to practice ethically. First, participants made (5) [efforts to foster an ethical organizational climate: care was taken to educate other staff members on ethical awareness, and conversations aimed at encouraging consensus building were held]. Second, they took (6) [initiatives to engage the organization in ethical practices: guiding staff members so that a neutral stance could be taken, where intuition and emotions were used as a guide in navigating the resolution of ethical issues].

When making (5) [efforts to foster an ethical organizational climate: care was taken to educate other staff members on ethical awareness, and conversations aimed at encouraging consensus building were held], participants in clinical situations were found to guide and prompt ward nursing staff to recognize certain issues. Developing the ability to practice ethically at the individual level is essential before ethical practice can become fully integrated at the organizational level. Therefore, it can be said that nurses can only truly develop the ability to practice ethically if they are able to identify these issues without external prompting.

This study also found that participants took various actions to facilitate these moments of understanding. Nursing staff may not always realize they are encountering ethical issues, even when they feel uncertain about what to do or sense that something is amiss. Being able to identify ethical issues is considered crucial to developing the ability to practice ethically. For this reason, raising awareness of ethical issues among nursing staff is essential [14, 15].

One participant in this study noted, "It's important to be there together and experience the same things together." Having CCNS present alongside other medical staff allows these staff members to learn how to perceive situations and address ethical issues effectively. This is thought to be particularly helpful for nurses who may be less skilled in dealing with ethical issues, enabling them to develop an informed perspective and, ultimately, the ability to practice ethically.

As for participants taking (6) [initiatives to engage the organization in ethical practices: guiding staff members so that a neutral stance could be taken, where intuition and emotions were used as a guide in navigating the resolution of ethical issues], those working in the nursing profession are said to possess intuition that allows them to detect subtle or vague information in unexpected situations. This intuition enables individuals to piece together seemingly insignificant details to understand the bigger picture and discern truths that may not be immediately apparent [16]. The extraordinary care provided by participants is thought to surpass this ability. Participants were not only required to use evidence and tools effectively but also needed the skills needed to facilitate collaboration among staff members in various roles, and present themselves in a manner that is acceptable in a clinical scenario. They also took care to present themselves in ways that would be positively received in clinical settings, ensuring patients felt comfortable. Recognizing that building positive relationships within the workplace is essential for successful cooperation, participants made deliberate efforts to achieve this.

Participants understood that Japanese culture was highly valued in their workplace, manifesting in behaviors such as refraining from speaking one's true opinion (as this might be perceived as selfish) and maintaining politeness, as noted [17, 18]. Despite this cultural understanding, participants recognized the necessity of being assertive when expressing their opinions.

2. How to implement ethical practice in the nursing sector moving forward

The provision of care deemed unbeneficial from a medical perspective has been identified as the most common cause of ethical dilemmas experienced by nursing staff in the critical care sector [19]. By becoming aware of available

resources, such as discussions on palliative care and ethical issues, ethics committees, and opportunities to express their challenging experiences, nursing staff can potentially reduce the trauma associated with these situations [20, 21]. Therefore, developing the ability to practice ethically requires not only individual effort but also the availability of organizational support systems. Creating an ethical organizational climate is essential to fostering awareness of ethical issues.

This study identified three logical structures underpinning the ethical practices of CCNS: consideration for patients and family members, consideration for organization members, and practice based on personal codes of ethics. Ethical coordination is a key responsibility of CCNS, and this study found that personal codes of ethics formed the foundation for their ethical practice. A clear understanding of ethical issues and personal principles related to ethical practice enabled nurses to make sound ethical decisions in situations requiring care. Participants were also found to actively engage in workplace activities that foster an environment conducive to developing the ability to practice ethically.

Facilitating discussions among medical staff to promote mutual understanding of each party's values, alongside the ability to identify and consider ethical principles, was shown to be important. Nurses must develop a personal code of ethics before forming a broader perspective on ethical issues. Additionally, the ability to recognize ethical issues, logically articulate one's thoughts and experiences, and reach mutual understanding through conversations were highlighted as essential.

Implementing frameworks that support the widespread adoption of ethical practices is necessary. Such frameworks should enable nurses facing ethical dilemmas in clinical scenarios to adopt the various steps demonstrated by CCNS in this study.

Limitations of the study, areas for future research

All participants in this study had extensive experience working as nurses and/or CCNS. While focus groups were used as a means of gathering data on group dynamics, the time constraints of this study may have limited participants' ability to fully discuss ethical practice.

Future research should aim to expand the scope of participants to include nurses in addition to CCNS.

CONCLUSIONS

The structures identified through data analysis revealed that the ethical practices of CCNS in the critical care sector was rooted in personal ethical values and an [awareness as the CCNS responsible for patients' lives]. Participants considered patients and their families while undertaking the following three actions: placing [emphasis on a patient-centered perspective], [facilitating consensus-building among healthcare professionals in the face of changing patient conditions and time-constrained situations], and [addressing conflicts in perceptions, thoughts, and approaches between patients/families and healthcare professionals].

In addition, participants made [efforts to foster an ethical organizational climate] and took [initiatives to engage the organization in ethical practices].

RESEARCH CERTIFICATIONS HELD BY THE AUTHORS

NT contributed to thesis writing, data collection, and the analysis and interpretation of data. YH conceptualized the study, designed its framework, oversaw the entire research process, and provided guidance on manuscript creation. HK and SM participated in data gathering and analysis. All authors reviewed and approved the final manuscript.

DISCLOSURE STATEMENT

The authors declare no conflicts of interest associated with this manuscript.

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