Simulated teaching and moral deliberation:
contributions to professional training in health

Dulcinéia Ghizoni Schneider
Flávia Regina Souza Ramos
(Organizers)

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Organizers:

Dulcinéia Ghizoni Schneider

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ORGANIZERS:

DULCINÉIA GHIZONI SCHNEIDER

FLÁVIA REGINA SOUZA RAMOS

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Mailing Address:
P.O. BOX 21.603 – Vila Ipiranga Porto Alegre/RS - CEP:91.360-970
E-mail: moriaeditora@gmail.com / www.moriaeditora.com.br

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ORGANIZERS

DULCINÉIA GHIZONI SCHNEIDER
Nurse. Master's and Doctorate in Nursing with an area of concentration in Philosophy, Health and Society from the Federal University of Santa Catarina (UFSC). Thesis awarded the Capes Thesis Award 2011. Adjunct Professor of the Department of Nursing, acting in the Undergraduate Course and Postgraduate Program in Nursing UFSC. Researcher at the Research Laboratory on Work, Ethics, Health and Nursing - Praxis of UFSC, in the research line Ethics and Subjectivity. Member of the Ethics Commission of the Brazilian Society of Bioethics, Santa Catarina Region (2018-2020).

FLÁVIA REGINA SOUZA RAMOS
Nurse. Master's and PhD from the Federal University of Santa Catarina (UFSC), with post-doctorate in Education from the University of Lisbon. Retired professor at UFSC. Visiting Professor CAPES at the Amazonas State University (UEA). Permanent Professor of the Postgraduate Program in Public Health Nursing (PROEnsp / UEA) and the Postgraduate Program in Nursing / UFSC. Researcher Productivity Scholar of CNPq (PQ 1A) in the themes of the work process in nursing and health, bioethics, ethics and education. Member of the Board of Directors of the Brazilian Society of Bioethics (2018-2020).

AUTHORS

Dulcinéia Ghizoni Schneider
Nurse. Master's and PhD in Nursing with an area of concentration in Philosophy, Health and Society from the Federal University of Santa Catarina (UFSC). Thesis awarded the Capes Thesis Award 2011. Adjunct Professor of the Department of Nursing, acting in the Undergraduate Course and Postgraduate Program in Nursing UFSC. Researcher at the Research Laboratory on Work, Ethics, Health and Nursing - Praxis of UFSC, in the research line Ethics and Subjectivity. Member of the Ethics Commission of the Brazilian Society of Bioethics, Santa Catarina Region (2018-2020).

Flávia Regina Souza Ramos
Nurse. Master's and PhD from the Federal University of Santa Catarina (UFSC), with post-doctorate in Education from the University of Lisbon. Retired professor at UFSC. Visiting Professor CAPES at the Amazonas State University (UEA). Permanent Professor of the Postgraduate Program in Public Health Nursing (PROEnsp / UEA) and the Postgraduate Program in Nursing / UFSC. Researcher Productivity Scholar of CNPq (PQ 1A) in the themes of the work process in nursing and health, bioethics, ethics and education. Member of the Board of Directors of the Brazilian Society of Bioethics (2018-2020).

Graziele de Lima Dalmolin
Nurse. Master's and PhD in Nursing from the Federal University of Rio Grande (FURG). Professor at the Nursing Department of the Federal University of Santa Maria (UFSM). Post-doctorate in progress at the Federal University of Santa Catarina (UFSC). Vice-leader of the Research Group Work, Ethics, Health and Patient Safety at the Federal University of Santa Maria (GTESSP/UFSM).

Isabela Saioron
Nurse. Master in Nursing from the Federal University of Santa Catarina (UFSC).
Doctoral student in Nursing, Postgraduate Program in Nursing, UFSC. Member of the Research Laboratory on Work, Ethics, Health and Nursing - Praxis at UFSC.

Jussara Gue Martini
Nurse. Master's and Doctorate in Education from the Federal University of Rio Grande do Sul (UFRGS). Post-Doctorate in Nursing from the Nursing School of Porto - Portugal. Professor and Researcher, Department of Nursing, Federal University of Santa Catarina (UFSC). Coordinator of the Postgraduate Program in Nursing (PEN / UFSC). Coordinator of the Internationalization Project (PrINT/UFSC), Subproject Interprofessional Education in Health. Researcher in the areas of nursing education, especially in the field of professional and teacher training and nursing in primary care. Research Productivity Fellow, level 2, CNPq.

Marina da Silva Sanes
Nurse. Master in Nursing from the Federal University of Rio Grande (FURG). Integrated Residency by the Conceição Hospital Group (RIS-GHC). Specialist in Health Education (Hospital Sírio-Libanês). Researcher at the Research and Technology Laboratory in Education in Nursing and Health at the Federal University of Santa Catarina (EDEN/UFSC). Member of the Advisory Group of the Board of Education of the Brazilian Association of Nursing (ABEN/SC).

Mario Sergio Bruggmann
Nurse. PhD student in Nursing from the Federal University of Santa Catarina (UFSC). Professional Master in Nursing Care Management. Specialist in Pre-Hospital Emergency. Nursing Manager of the Psychiatric Institute of the State of Santa Catarina and Santana Living Center. Member of the Research Laboratory on Work, Ethics, Health and Nursing - Praxis of the UFSC.

Mirelle Finkler
Dentist. PhD in Dentistry with internship abroad in Bioethics at Universidad Complutense de Madrid. Professor, Department of Dentistry. Professor of Postgraduate Programs in Collective Health and Dentistry. Vice-leader of the Center for Research and Extension in Bioethics and Collective Health at the Federal University of Santa Catarina (UFSC). President of the Brazilian Society of Bioethics, Santa Catarina Region (2018-2020).

Saionara Nunes de Oliveira
Nurse. Master and Doctoral student by the Postgraduate Program in Nursing at the Federal University of Santa Catarina (PEN / UFSC). Instructor in Simulation by the Universidad de Costa Rica (UCR). Member of the Brazilian Association of Simulation in Health (ABRASSIM) and the Federación Latinoamericana de Simulación Clínica y Seguridad del Paciente (FLASIC).

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FOREWORD

The theme on which this book focuses - the teaching of moral deliberation in ethical problems in nursing education - is of growing importance in the 21st century. As Harari[A] states in his book *21 lessons for the 21st century, "in a world filled with irrelevant information, clarity is power. If there is no longer any restriction on the flow of ideas, the logic of censorship seems to have been subverted: the excess of content that people are exposed to on a daily basis floods them with misinformation and distractions."*.

In this sense, when we think about professional training in health, the contents related to subject knowledge (one of the seven knowledges necessary for teaching practice, as proposed by Shulmann [A]) are no longer ends in themselves, but strategies for the development of autonomous citizens, with social commitment and ethical responsibility. In this context, the development of ethical and moral competencies becomes important, such as interpersonal communication, negotiation skills, cooperation and teamwork, respect, and leadership. These competencies have been historically neglected in the context of the training of nursing and health professionals.

Learning to relate is both a requirement and a huge challenge. It requires new teaching models. New models that are not only new methods, new ways of teaching and learning, but fundamentally the transformation of paradigms in health education. The adoption of new teaching methodologies needs to be preceded by a strong and consistent theoretical base that supports it.

Educate for what, for what purpose? For Freire, to educate is to promote awareness - of oneself and of the world. Only with a critical attitude towards the world is it possible to achieve epistemological consciousness. To awaken epistemological consciousness in students is the great goal of education, understood as that in which the human being, faced with the world, leaves his/her naive conscience behind and develops a more centered perception of *himself/herself, his/her world and him/herself in the world*. They perceive themselves as subjects in a changing world, capable of promoting

[A] SHULMAN, L. S. Conocimiento y enseñanza: fundamentos de la nueva reforma. **Profesorado**, Granada, v.9, n.2, p. 1-30, 2005.

changes through their own action. Through the apprehension of reality, the human being reaches epistemological consciousness, a state in which he/she overcomes the limits of just knowing oneself, "aware" of reality, and begins to act on it as the object of his/her action, that is, as praxis. Reaching this consciousness requires time, continuous exercise and feedback, because it unconditionally needs the awareness. (FREIRE, 2001)[B]

To reach awareness, education needs to overcome transmissible and vertical modes in order to privilege inter-dialogical and, therefore, horizontal spaces. It is in democratic spaces that autonomous citizens are built, who are moved by respect, understanding, and empathy. For the student to be able to build his personal and professional autonomy, the teaching process needs to enable experiences that stimulate decision making and responsibility, that respect the student's freedom to act. (FREIRE, 2014)[C]

Learning implies experimenting, modulating the gaze - the critical ability to think about, to mobilize emotions and feelings. And, in this sense, the error is also learning. In learning spaces it is necessary to allow the student to make mistakes, ensuring his safety and that of everyone involved.

Therefore, it is necessary to think about the teaching of moral deliberation in ethical problems as a fundamental content in the training of health professionals, in learning spaces that allow modulation of the gaze and experimentation. And, in this sense, simulated teaching presents itself as an exceptional pedagogical resource, as it allows the student to experience daily situations, respecting his pace and learning time, which in his future professional practice will present themselves, with the desired security. Such situations of conflict and complex moral and ethical problems, which present themselves in everyday health care services, require the learning of decision making processes and the development of ethical sensitivity, which in transmissible models of education, are rarely placed as "learning content".

And if we learn throughout our lives, this all applies to permanent education processes. We are eternal learners, as Freire said. That is why, also in continuing education movements, it is necessary to have reflective and dialogical spaces in the

[B] FREIRE, Paulo. **Conscientização – teoria e prática de libertação**: uma introdução ao pensamento de Paulo Freire. 3.ed. São Paulo: Centauro, 2001.
[C] FREIRE, Paulo. **Pedagogia do oprimido**. 50.ed. São Paulo: Paz e Terra, 2014.

work context, which allow the health professional to think about the ethical and moral problems experienced and, in a process of action-reflection-action, to modulate his ethical conduct in order to provide safe and quality care.

And, perhaps, the greatest provocation of this book is for teachers, nurses, and other health professionals. Because recognizing the importance of ethics education as proposed in this book requires a redefinition of the role of the teacher. Not as one who teaches, but as one who creates meaningful learning spaces; one who offers alternatives for the student to build his/her own learning paths, allowing the modulation of his/her outlook; a teacher who creates democratic environments that stimulate the participation and the reflexive and critical capacity of his/her students; a teacher who gets off the stage, and gives the stage to the students - from protagonist to supporting actor. For this, he/she needs to recognize the necessary competencies for the exercise of teaching, building him/herself as a teacher. After all, we are trained health professionals and, rarely, nursing and health teachers.

And finally, to reaffirm that conflicts and ethical dilemmas are not experienced in isolation in the context of health work. That is why it is necessary to learn, in the initial training processes, to share and reflect together for collective decision making. And, in this sense, the teaching of moral deliberation in ethical problems in the initial training of nursing and health professionals presents itself as a strategic content to promote inter-professional education (IPE). We need to build collaborative practices in health, beyond disciplinary boundaries.

Hopefully, reading this book will provoke us to think and act, provoking our own disagreement for the necessary transformations required for health care in the 21st century, in the world of work and in the world of teaching.

Dra Marta Lenise do Prado

Nurse. PhD in Nursing Philosophy

Full Professor at the Federal University of Santa Catarina (UFSC) and Visiting Professor at the Federal University of Amazonas (UFAM)

PRESENTATION

This work was produced from the research "Simulated teaching applied to the moral deliberation process in ethical problems experienced by nursing students and professionals", financed by the Coordination for the Improvement of Higher Education Personnel/CAPES, Capes Thesis Award 2011 reverted into Research Project Funding. The research project was approved by the Ethics Committee for Research involving Human Beings, via *Plataforma Brasil*, under CAAE no 41840915.1.0000.5361 and consolidated opinion no 990.530.

Its intention was to support the development and application of simulated teaching strategies to the process of moral deliberation in ethical problems experienced in nursing education and professional practice. However, in the field of collective health work, moral problems and the search for solutions mostly involve multiple actors. Health work is developed by multi-professional teams, and moral competencies are required from all these workers. Thus, the centrality of the experience of professionals and students is assumed as an object of problematization and, therefore, a focus for the development and application of reflective educational tools.

It is hoped to stimulate teachers and professionals to reflect on moral issues, often invisible in clinical activity and health care management, as well as on educational strategies that promote ethical and moral competencies. Hence, perhaps the greatest product is to offer a guide or script to rationally elaborate and develop moral deliberation, or the critical analysis of specific situations/problems, among those pointed out as examples and many others of interest to professionals.

Readers will note that although the development of competencies for moral deliberation is on the horizon, at least two expansions of focus are mobilized:

1) The recognition that many of the issues brought up by the daily practice of professionals and students do not refer to classical problems of clinical bioethics. Even if they provoke insecurity and doubt and demand moral positioning, they are often conflicts of relationships or confrontation of institutional barriers, not involving a clear conflict of values or not presenting all the necessary components for a deliberation in collective sessions. In this case, it is worth asking: - if these issues are so common, if they cause anguish

and if they can threaten the care of people and the quality of relationships, why shouldn't they be treated with equal importance and responsibility? And, to address them, what lessons can we learn from the process of moral deliberation? Does deliberation necessarily have to be limited to clearly configured "cases" within the proposed method? Or can we, making use of what the referential and deliberative method teaches us, exercise critical looks at our problems and our limits in more daily decisions? Believing that yes, it is worthwhile to exercise our reflection on the daily routine of health work, and thus, this first expanded reading of the moral deliberation method is made.

2) The recognition that professionals, and especially teachers, in their strategic choices facing the educational task, are presented summoned and even seduced by diverse references and tools, without the choice of a method being accompanied by a critical reading of its theoretical basis. Thus, sometimes, teachers put themselves in the position of deciding to apply a resource, still with doubts about its consistency or coherence with assumed values. In terms of the referential and the method of moral deliberation there is, for example, a close relationship, in origins and ends, with narrativism or narrative bioethics. But how are they similar how are they different? Can understanding their connections help devise alternatives or applications better adapted or targeted to certain contexts or issues? Can new scientific evidence and discourses on education and morality be helpful? Are they contrary to or complementary to the contributions of deliberation, narrativism, or simulated teaching? Should what is controversial be dismissed or should it be the subject of discussion, as in the case of topics such as neuro-education and neuro-ethics? It is because of these questions that a second broadening of the referential was opened, towards possible dialogues with other concepts, such as moral sensibility, or propositions derived from the knowledge of neurosciences or simulated teaching practices, or how these are also attuned in some aspects.

For this reason, this work is organized in three parts. The first part presents the theoretical framework produced from the contribution of different authors, brought together not only because they have already found coherence relations, but also because

they raise new questions and applications. At the end of this first part, a synthesis is presented, in the form of a Referential Matrix for the development of problematizing strategies in ethics education, such as the approach to moral problems and simulated teaching. The second part is composed of two chapters that deepen the two privileged axes of the work, moral deliberation and simulated teaching. The third part of the book points out practical paths by providing a Guide to understand, apply, or construct exemplary cases of moral deliberation, inspired by the stages of Diego Gracia's process of moral deliberation (presented in chapter 3), but that can be useful in adaptations for diverse teaching situations, in the approach of more everyday experiences and problematizations, which do not always constitute complete sessions of discussion and decision in teams. Finally, the articulation of education for moral deliberation with the realistic simulation method is demonstrated, by means of an experience report. Importantly, the moral deliberation cases to be constructed cannot be considered "real cases". Although inspired by real situations, they should be re-appropriated, synthesized, and transformed, only referring to the type of problem, without any reference to concrete persons. This elaboration can also take place in a continuous process of discussion among different participants, in order to get closer to the experience of professionals and students.

The work can be read in several ways. It is hoped that its contribution can promote reflection on the references that underlie educational activities in professional training scenarios in health, in undergraduate and continuing education. The most important thing is that teachers, students, and health professionals appropriate what the work offers as an example capable of mobilizing sensitivity, creativity, and the collaborative construction of strategies for the development of their own ethical and moral competencies.

Dulcinéia Ghizoni Schneider

Flávia Regina Souza Ramos

PART 1

1
THEORETICAL FRAMEWORK: POSSIBLE ARTICULATIONS?

Flávia Regina Souza Ramos, Dulcinéia Ghizoni Schneider, Graziele de Lima Dalmolin , Isabela Saioron, Mario Sergio Bruggmann

This chapter presents the proposition of a possible theoretical foundation for the interest of subsidizing approaches to the teaching of ethical topics or, in the expanded sense that is desired, to enhance ethical and moral competencies in the process of professional training, in facing ethical problems and demands for moral deliberation.

Starting from a brief portrait of the context that involves the work-education relationship, specifically in the historical and sociotechnical cutout of the health and nursing fields, we move on to some theoretical bases and concepts elected for their contribution to thinking about the objectives and strategies of the educational actions that privilege the ethical dimension of the formative journey.

The scenario: from work to health training and the challenge of developing ethical and moral competencies

In recent years, the health care system around the world has undergone changes that include technological advances, new diagnostic tools and techniques, new care processes and medical interventions, as well as budget constraints and reforms. In this context, attention to the health of health workers and to ethical and moral issues are often relegated to the background, because the major emphasis in work organization is the growing concerns with cost containment, cost-effectiveness, and the use of technologies, which has contributed to a greater emphasis on mechanistic professionalism, as opposed to the need to review ethical conduct.[1,2]

Workers are frequently exposed to moral problems in their daily work lives. In nursing, Jameton3 differentiated three categories of moral problems that affect nurses, that is, moral uncertainty, moral dilemmas, and moral suffering. Moral uncertainty occurs when the professional does not know the ethically correct course of action, but feels a nagging uncertainty, a sense that something is not right, often remaining silent because he/she considers him/herself alone or for fear of appearing unwise when asking questions. Moral dilemmas occur when there are two opposing options for actions, which may equally ethically justify the agent, who is unable to perform both actions, and is faced with a dilemma in having to choose a course of action to follow because

there is no strong enough argument to indicate one option over the other. And, moral distress occurs in situations where the professional makes an assessment and recognizes the ethically appropriate action to be followed, but due to internal or external constraints feels prevented from acting according to his/her conscience.

The experience of these moral problems in health work has implications for the workers, such as leading them to experience moral residue, which refers to the experience of compromised moral integrity, involving the annulment or violation of beliefs, values and principles, which can lead to professional indifference.[4] It can also be said, that as moral problems focus on the moral component and moral agency of these workers, they can also constrain their moral sensibility.[5]

It is corroborated that the growing complexity of contemporary moral and ethical conflicts and problems in health care services constitutes a challenge to the academic training of these workers.[6] The main strategy to avoid the naturalization of these moral problems and to keep the workers in their positions is ethical education, including the training process and continuing education.[7]

In this sense, it is emphasized that reflection on the ethical issues of day-to-day work should already occur in the process of training workers, as a strategy to facilitate the perception of conflicts and ethical problems of everyday life, and to assist in the construction of solutions that favor the strengthening of workers in the necessary confrontations.[8] One possibility is to invest in the development of moral sensitivity, since each student already has a degree when starting the course, but this should be strengthened and encouraged through programs and courses in ethics, for the improvement of skills and abilities in the reflection and confrontation of moral problems in practice, avoiding moral wear and suffering.[9]

Thus, the importance of ethical education and the development of moral sensibility is resumed, which has positively influenced the development of health workers' confidence, the use of ethical resources, propitiating moral actions and cultivating ethically upright environments. Ethical education is essential for the moral action of the workers, favoring their actions as defenders of the patient and their greater participation in resolving ethical challenges at the bedside.[10] Ethical education also proposes the teaching of strategies that stimulate the exercise of workers' power, with appropriate behavior models to face situations of dilemmas and moral suffering, as well

as to establish effective interpersonal relationships at work, that is, to prepare them for ethical dialogues with all the professionals in the team.[11-12]

The teaching of ethics in undergraduate Nursing has been discussed and questioned as to the best strategies to be adopted, aiming at developing competencies, not only technical, but also ethical. The isolated disciplines of professional ethics develop the deontological view of ethics, with discussions about the Professional Code of Ethics (PCE) and situations in which the non-compliance of the professional's attitude with what is prescribed in the Code or in the Professional Practice Law (PPL) results in infractions. It is fundamental that the student knows his/her PCE, as well as his/her PPL. It is also important that the student, when experiencing situations of conflict or ethical problems, can perceive and identify which attitudes are appropriate or inappropriate and how best to deliberate morally, so that the results of decisions are the best, both for the patient or family, for the professional and his/her team, and for the institution that proposes to provide quality care.

The cross-curricular teaching of ethics is a long-discussed proposal, but little put into practice, because for there to be cross-curricular teaching in undergraduate courses, there must be integration in the curriculum and teachers need to be aligned in their teaching/learning strategies and have conducts that aim at a result or impact on learning.

Ferreira and Ramos[13] emphasize the importance of planning and systematizing the teaching of ethics and bioethics in undergraduate nursing curricula in order to enable students to make decisions autonomously and reflectively in the various contexts of practice. As proposals, these authors suggest, in addition to qualified teachers, the transversal teaching of ethics/bioethics, the development of values, virtues and ethical attitudes by the students, as well as consistent references to support the teaching.[13]

The interaction of the student with real work scenarios provides the construction of relationships with users of health services, the family and the community and, in this relationship, ethical implications arise, resulting from the challenges of reality.[14] In this moment, the student relates theory and practice to critically analyze situations and select the best conducts.

Moral sensitivity and health training

Moral sensitivity is understood as the ability to recognize a moral conflict, showing a contextual and intuitive understanding of the patient's situation of vulnerability, with an insight into the ethical consequences of decisions made on behalf of the other[15,16], involving the dimensions of interpersonal relationship, moral structure, benevolence, autonomy, and the professional's confidence in his values and knowledge.[15] In this sense, one must first recognize, and then show sensitivity when faced with a situation in which the patient is vulnerable, in order to make ethical decisions.[9]

The development of moral sensitivity among undergraduate health care students is necessary for effective ethics education, since moral sensitivity is the main prerequisite for ethical performance.[2] It is emphasized that the performance and ethical conduct of the professional is inseparable from the provision of quality and safe care, based on the requirements of patient safety, which are also shaped by the principles of bioethics, considering the obligations and duties of professionals as well as health institutions.[17] Thus, it is understood that quality care involves an ethical posture and moral sensitivity on the part of the professional, aiming at patient safety.

Among the factors that are most representative in the expression of moral sensitivity are the personal factors, such as perception of conflict, benevolence, personal values and responsibility, and also the contextual factors, such as training and professional practice, the ethical climate in the work environment, the rules and regulations in line with professional values and workloads. Thus, moral sensitivity should involve awareness, perception, and interpretation of the ethical problem for justifiable and prudent decision making, which can be stimulated from supportive and teaching strategies such as ethics education.[9]

Some studies have already been conducted internationally on moral sensitivity in nurses and nursing students. One study found relatively low levels of moral sensitivity among Korean students,[18] others have analyzed the impact of social and personal aspects on moral sensitivity among nursing students.[16,19] A more current study searching for associations between socio-demographic and student data with moral sensitivity identified that gender, age, and family status have a significant association and should be considered when designing ethics education for nursing.[20]

Still as an example, another Korean study described the relationship between nursing education and the moral development of its students, with an assessment of the level of sensitivity and moral reasoning of beginning and final students. Significant differences were observed, since the latter showed greater perception and sensitivity in patient care, their rights and autonomy, perceived situations of moral conflict, and identified professional values and had greater confidence. Thus, it is emphasized that moral sensitivity and moral reasoning skills are extremely necessary for ethical performance and decision-making in nursing, and should, as ethical education, constitute the undergraduate curricula.[19]

Similarly, in their daily lives, health professionals experience ethical conflicts and dilemmas without often having sufficient subsidies to make an ethical decision. In some situations, they know what the best option is, but lack the necessary resources; in other situations, they are hampered in their ability to decide, or even do not know how to decide. In this sense, it is necessary to have discussion and analysis of the situation for moral deliberation to occur.[21]

Neuro-education and neuro-ethics as tools for developing moral sensitivity and deliberative skills?

Currently, the advance of knowledge in neuroscience is unquestionable, and it is being applied in different contexts and particularities, including the study of ethics and education.

Neurosciences can be understood as experimental sciences that aim to explain the functioning of the brain through observation and experimentation, showing that different areas of the brain have different specializations and functions, sometimes interconnected.[22] In the same way, its concept involves the study of the nervous system, including the brain, bringing together a series of specialties, such as molecular biology, biochemistry, medical physics, among others, as well as constituting a discipline in itself. Neuro-scientific studies have widely addressed neurological structure and function, what roles parts of the brain play, and their associated physiological and cognitive processes, greatly motivated by the use of neuroimaging. In this sense, advances have been recognized along with genetic, cellular and computational approaches, favoring different perspectives, such as the studies of neurological injuries,

neurosurgery, pharmacological applications to neural circuits, being also applied to addiction, learning, memory, emotions, sleep, among others.[23]

It is the neuroimaging techniques that have allowed access and greater understanding of the brain's functioning and its localized activities, by means of structural and functional magnetic resonance imaging, allowing the advancement of neurosciences, and its specializations, since from the recognition of the locations and activations of the brain bases it has grounded other areas such as education and ethics, establishing new terms like neuro-education and neuroethics.[24]

The neurosciences present a possibility to improve learning based on knowledge about brain functions. Thus, the so-called neuro-education proposes the construction of bridges between basic neuroscience and its possible applications to favor education (neuroscience applied to education), harmonizing teachers' teaching methodologies to students' learning techniques,[25,26] and may be characterized as an important tool for ethical education in nursing, together with the application of neuroscience knowledge to the ethical constitution of students and professionals.

In this topic, an approach and reflection on the incorporation of neuro-ethics and neuro-education for the development of moral sensitivity and ethical decision making among nursing students and professionals was sought. It is assumed that the risks of non-critical or mystifying assimilations of neuroscience knowledge can only be faced by reading this knowledge and its propositions, out of any aura of neutrality, but always demanding an effort of articulation with the assumed educational purposes and conceptions. In this way, contrary to an apparent incoherence or inconsistency with the referential assumed in the other topics, what we want is to question the potentials of articulation and support that can be provided.

Neuro-education uses this kind of knowledge to develop ways to favor the educational process according to how the brain interacts with its environment, since neuroimaging techniques show the brain areas activated in the cognitive and emotional learning process. In this way, it becomes possible to identify the natural way of human learning and whether certain educational methodologies developed are really more efficient.[22,26,27] Neuro-education integrates three areas in its approaches: psychology, education, and the neurosciences. In this way, Neuro-education emphasizes the importance - albeit timidly - of the role of emotions and of the socio-economic-cultural

context in learning, and of the various possibilities of motivating students to learn. For teachers, this information would be used to improve their classroom practices.[27-29]

Neuro-ethics can be distinguished into two strands, one being the ethics of neuroscience, and the other the neuroscience of ethics. The first refers to the development of an ethical framework that aims at regulating neuro-scientific research and the application of its knowledge to human beings, being considered an applied ethics, a branch of bioethics. The second refers to the application of neuro-scientific knowledge to ethical conduct itself, identifying the brain bases of moral agency.[22]

In view of the concepts presented, it can be said that the application of neuro-ethics and neuro-education in nursing, essentially in ethics education, can favor decision making and the constitution of ethically healthy conducts and subjects in the spaces of action (or, at least, a better understanding of these processes), both for students in training and professionals in continuing education. These could constitute tools for moral deliberation based on the development of moral sensibility?

Perhaps at this moment we are not yet in a position to consistently articulate these processes, without falling into reductions (to one side or the other) or neglecting the complexity of human moral experience. What we cannot doubt is that we are moving towards the recognition that no single approach is sufficient or able to deny the need for new resources and dialogue between knowledge.

For example, a meta-analysis studied 45 experiments with 959 participants, 463 foci of activation in 43 selected articles investigating the neural mechanism of moral functions, comparing neural activity in situations involving and not involving moral issues, identifying common foci of brain activation, and comparing neural correlates of moral sensitivity and moral judgment as two functional components of the neo-Kohlberian model of moral functioning.[30] The aspects of the moral functioning model encompass moral sensitivity, moral judgment, moral motivation, and moral personality. The first is understood as the ability to perceive a potential moral problem in a given situation, which interacts with each other to produce moral behavior, the second relates to the decision-making process, the third is the ability to prioritize the moral value over others, and the last refers to the tendency to sustain moral behavior. All interact with each other.[31-32]

Thus, in the meta-analysis, it was evidenced that the brain regions show greater activity during situations involving moral issues, in addition to identifying the areas that

were activated in moral sensitivity and moral judgment, differentiating them. The study showed that moral functioning, default mode network and autobiographical memory processing are associated with each other at the neural level. Furthermore, it evidenced that brain regions (right temporal-parietal junction and supra-marginal gyrus) showed significantly higher activity in moral judgment than in moral sensitivity. Thus, it could hypothesize interventions to improve moral functioning based on the temporal-parietal junction, in the case of judgment, and on the default mode network, in the case of sensitivity, using MRI.[30]

Another study corroborates this when, using the functional magnetic resonance imaging technique during the application of cases to participants, it observed that moral sensitivity and social agency share a large amount of a specific but distributed neural system. That is, when the situation referred to emotionally neutral agency, as related to normative social behaviors, neural networks linked to default mode and moral sensitivity were activated and shared. When other moral emotions were aroused, such as guilt, compassion, embarrassment, indignation, among others, different patterns were activated, indicating that additional activation of brain function is provoked by different moral emotions. That is, when a violation of moral values and expectations occurs, the neural network balance is disturbed, generating increased activity of regions within this circuit, as experienced by different moral emotions[33]

Thus, based on the evidence of the activation of different brain areas and neural networks according to different stimuli, comprising moral actions and possible decision making in conflicting situations, the question is how this could be used for the improvement and ethical education? Or how the different areas that favor moral sensitivity or moral judgment could be stimulated for better performances, without interfering in the subject's personality constitution, or without the complexity of the different individual, social, and cultural factors that act on moral decision and conduct being reduced to neurological functionalities?

In this perspective, an example of a tool that has been studied is neuro-feedback-based moral enhancement, which some authors suppose could be part of the traditional moral education network. Neuro-feedback uses devices such as real-time functional magnetic resonance imaging (rtfMRI), decoded neuro-feedback (DecNef) or functional connectivity-based neuro-feedback (FCNef), which require the subject's counterpart to perform the proposed techniques and exercises, allowing them to adjust

their brain states using a real-time representation of brain activities, self-regulating their emotions, cognition and behavior.[34,35]

Neuro-feedback for moral improvement can be encouraged because it has already been applied in the general population and in cases of disorders to help adjust behavior. It merely decodes information about the brain without intervening specifically. Training can be customized by focusing on the region of interest or voxel level. Also, neuro-feedback can be considered safe, because it doesn't adopt a specific notion of morality, and uses techniques that require the subject's counterpart, i.e., voluntary activity, thus also avoiding fraud by requiring the participant's effort until it reaches the target brain state, as well as maintaining moral diversity, unlike the use of drugs, for example.[34,35] Even when such applications are presented as safe and non-interventionist, it is important to consider uses and consequences that go beyond the immediate uses. For example, what criteria can be used to define what kind of behavioral "disorder" would be caused by this type of technique, and from the point of view of what interests? How to ensure that these interests are those that preserve the full rights of the subjects? Is there a need for specific and detailed ethical norms, including the safeguarding and use of the information accessed, including for future interventions, as happens with genetic material?

Narrative bioethics

For Moratalla[36] narrative bioethics can only be understood in articulation with hermeneutic bioethics (philosophical foundation) and deliberative bioethics (method), without which it would be a simple naive instrument.

Narrative bioethics is a way of doing bioethics, and also a perspective, or way of seeing realities and problems. It seeks, above all, sincerity with human experience, in an effort to rigorously address the ethical issues of health work, approached as "medical ethics", but which has been expanded to a multi- and inter-professional perspective. In this field of health, it is applied in the revitalization of bioethics' original intention - of bridging disciplines - to articulate encounters of these practices with artistic creation, (literature, cinema, poetry). Thus, it has a formative and self-formative vocation, in proposing the educational renewal of bioethics. If education in bioethics presupposes knowledge, procedures, and attitudes, narrative bioethics contributes to this attitudinal

and subjective element, of narrative sensibility, indispensable to the deliberative process, precisely because narrative knowledge deals with the uncertain world of life.[36]

Professional health practice is marked by the encounter of subjectivities. The daily care is made "of" and "in these" encounters, in which narrative has a special place, because the experiences of living, getting sick, suffering, and caring are narrated, understood, and interpreted. Similar to a reader who intends to be a critic, a professional is expected to have the ability to analyze ethical issues within narratives, loaded with beliefs, values, and meanings. Narrative competencies refer to the ability to interpret and act on other people's stories, building bridges to more empathetic and truthful relationships. They are abilities to understand what the stories express, which go beyond deductive logical rationality, but indicate a sense or narrative rationality, and also to respectfully handle situations that involve the other person. They can be understood as competencies to - transporting oneself to the narrated world (emotional resonance) - changing perspectives (empathic imagination), and adopting another's point of view (seeking internal coherence in the narrative).[37]

Still on the relationship between narrativity and moral deliberation, Almazán García[38] resumes the deliberative moments proposed by Diego Gracia - deliberation on facts, on values, and on duties - to indicate that in all of them, narrative reason imposes itself by resorting to the trilogy imagination-empathy-moral attitude. Even the moment of deliberation over the facts, so directly recognized by its objectivity, one can never separate human facts from experiences, dramas, biographies, projects, and intentionality; in short, the fact needs to be understood within the horizon of those who give it meaning. The task of understanding includes accessing the different perspectives that shape the facts.[38]

Assuming that moral deliberation can be learned and improved, Narrative Bioethics offers promising resources for this, since narratives can be used as tools of knowledge of human life. Through the exchange of narratives, one can better understand human intentions, conditions, and actions[39] that are essential to the deliberative process.

From this perspective, narratives need to be stimulated and properly conducted in order to favor moral deliberative processes. To this end, the narrativist strand advocates the use of various artistic resources, from paintings to poetry. The use of artistic languages is considered fundamental to human interactive processes and should

not be neglected,[40] and they are the ideal link to connect the scientific with the humanistic.

By balancing the scientific and the humanistic, the pragmatic and the narrative, Narrative Bioethics maintains the integrality of individuals, enabling the construction of knowledge and learning in a full way, respecting and maintaining sociocultural contexts, values, and other individualities. Thus, Narrative Bioethics favors the deliberative exercise by providing unavoidably fertile means to the construction of ethics for the analysis of problems related to moral values, through the sharing of cultural and social aspects, besides the deliberative exercise.

Narrativism can also be an excellent didactic instrument, and is particularly promising for deliberative education. The deliberative method is recognized as the most appropriate for making prudent decisions, where the rationality used is neither classical nor positivist, but descriptive, argumentative, hermeneutic, and especially deliberative. It has great potential for introducing social, cultural, and environmental issues into deliberative educational processes, broadening horizons beyond biotechnological issues.[39-42] In other terms, Narrative Bioethics proposes narrative deliberation as a methodology of interpretation and decision-making, a hermeneutic mode of knowledge and ethical attitude.

Narrative Bioethics seeks to solve ethical problems by emphasizing deliberative processes, recognizing and utilizing the unique experiences of each being. It can be said that learning to deliberate is the purpose of narrativism, which is a complex task that requires practice.[39,43]

By analyzing the "whys," the "what for," and the "hows" present in narratives in the face of moral problems, it becomes possible to develop more empathetic and prudent deliberations, favoring the elaboration of options and the probable choice of the best conduct for that context addressed.

The moral deliberation process

In clinical bioethics there are some methods of moral analysis, which allow a rational, systematic, and objective study of moral conflicts that arise in patient care, so that the decision taken is a prudent act. These models were developed by European and American bioethicists, and any one of them can help health professionals and Bioethics

Committees to reach a satisfactory result, serving as a starting point for training in the methodology of case discussion.[44]

In ethical decisions it is not enough to appeal to intuition or common sense because uncertainty accompanies most situations that require moral positioning. It is important to appreciate the particular circumstance and use systematized procedures for decision making. In the deliberation process of ethical problems one must consider the values and duties involved in the facts in order to examine the situation of moral conflict, in a reasonable and prudent way, through discussions and decisions made in interpersonal dialogue.[45]

Deliberation is an art, based on mutual respect, a certain degree of intellectual humility or modesty, and the desire to broaden one's own understanding of facts by listening to and exchanging opinions and arguments with others involved in the process. Deliberation is a public and critical way of analyzing one's own views. It requires certain knowledge, but mainly certain skills, and above all certain character traits. A person with severe psychological restrictions, unconscious fears or rigid prejudices, without the ability to analyze and verbalize them peacefully and without anxiety, will have a reduced capacity to actively intervene in a deliberation process.[46]

> Deliberation is a systematized and contextualized itinerary of analysis of ethical problems in order to find concrete solutions among prudent alternatives. This analysis is not abstract, but considers the circumstances of the act and the foreseeable consequences. The goal of deliberation is prudent courses of action. In clinical bioethics, prudence is expressed in the ability to value what is involved in the case with a view to reasonable decisions.[45:393]

Experience shows that the deliberation process itself acts as educational, improving the capacities of the people involved in it. It can be said that nobody knows how to deliberate in a natural way. Deliberation is not a natural behavior, but a moral one. In a natural way, everyone believes that they possess the truth and thinks that everyone who holds opinions or beliefs different from their own is naive or evil. Deliberation is a process of self-education. Perhaps it is also a process of self-analysis, and to some extent therapy. Socrates spent his life educating young people through deliberation, or in the process of deliberation. Socrates didn't answer questions; he only helped people to find their own answers to the questions.[46]

Practical reason is deliberative, but deliberation is a difficult task. It needs many possibilities, such as the absence of external constraints, good will, the ability to

give reasons, respect for others when they disagree, a desire for understanding, cooperation, and collaboration. This is the framework for a true deliberation process. Deliberation does not rely on decision, but on compromise. Deliberation theory is appropriate at the micro-level, at the level of interpersonal relationships and small group work.[46-47]

There are several models of ethical decision making and they should be applied to the ethical problem situations experienced by health professionals, avoiding decisions guided only by intuition, which are not always the best options.[45] Using these decision making models in simulated situations in health training will provide the development of cognitive skills related to ethics, so fundamental and little applied in training and continuing education.

A deliberation model considers at least four main components, ranging from the analysis of the consequences/impacts of decisions on the parties involved, through the weighing of conflicting values, the choice of the best alternative, to the dialogical exposition of the reasons justifying it.[48] Diego Gracia's proposal[46] also considers, in this deliberative itinerary, deliberation on facts (presentation of the case, clarification of the facts, preliminary information, hypothesis raising); deliberation on values (identification of the ethical problems of the case; indication of the fundamental ethical problem and identification of the values in conflict); deliberation on duties (identification of the extreme, intermediate and optimal courses of action) and deliberation on responsibilities (submission of the optimal course to the tests of time consistency, publicity and legality).[45]

The discussion about the deliberative process is still recent in the health sector, and its principles are more used for political decision-making than for health decisions, such as those related to nursing care and others that involve a large part of the work demand of a health team.[41,49-50] Health professionals commonly perform their activities in troubled work environments, with high workloads, reduced time dedicated to the sick, economic/material restrictions, and increased demands and challenges, which lead to fatigue, insecurity, and often hasty and poorly thought-out decision-making. The deliberative process and the moral problems/conflicts themselves are underestimated, reducing their complexity and limiting themselves to simplistic or extremist solutions.[51-52]

Moral deliberation is a process that aims to reflect on the moral issue, improving the quality of its resolution, as well as enhancing the moral competencies of those involved, allowing them to ponder on institutional or organizational issues.[53-54] It is a procedure that requires from those involved the ability to mediate and negotiate, correlating the moral aspects that surround it, among moral judgments that emerge from the dialogue between people receptive to the process.

Thus, the act of deliberation should be a collective approach, contemplating the evidence and interpretation through discussion, definition of priorities and co-creation of solutions, under the influence of the tacit knowledge of the participants of the process, favoring mutual understanding. The deliberative process can be considered a facilitating tool for decision making in clinical settings and requires professional skills, such as safety, self-control of emotions, and psychological maturity so that deliberation can be carried out seriously, efficiently and effectively, where those who deliberate become responsible for the impacts resulting from this process.[45,48,50,52,53,55]

When it is possible to link the deliberative process theme to continuing education/education, deliberation becomes even more advantageous, both for the professionals and for the institution that encourages it, since one of the most important characteristics of this process is the adequate combination of participants, the appropriate use of research evidence, an appropriate meeting environment, and the commitment of the participants.[49-50]

Ethical training and the teaching of moral deliberation

Ethical formation cannot be reduced to the teaching of ethics, even when considering formal educational processes, as is the case of professionalization in health. Ethical formation, or the development of the moral subject, occurs throughout life, in multiple and continuous social processes. These processes can be taken from the point of view of the configuration of individual and social identities, here using Dubar's perspective,[56] including from primary socialization and far beyond professional socialization.

If we think of ethical formation or moral education as dynamic and permanent, schooling and professional training will also have such an ethical dimension, or will have an important participation. In becoming a professional, one builds an identity,

relationships of belonging to a collective, and acquires models and references that function as guides to perception, judgment, and action.

This education of the look, gesture, and reason does not only take place in the classroom lessons, but in multiple 'lessons' and vectors. In formal education we have to consider the weight of the parallel curriculum, experienced in extramural activities, as well as the hidden curriculum, which, along with the more visible forms of learning, promotes the incorporation of values, behaviors, and a social/professional culture by the students, contributing to the adjustment of the individual to the group.[57-59]

Bioethics itself can be understood and problematized from two theses: I) bioethics as a potential "abstract system capable of producing reflexivity, ordering the experience and the project of subjective identity of the health worker"; II) the ethical/bioethical formation of the health worker as inseparable from a set of pedagogical devices that relate the world of work and the world of school in 'ways of being professional.[60]

This means to articulate formation and identity, to broaden the notion of formation and critically consider the potential of knowledge such as bioethics, which, by proposing itself as a necessary basis for the morally responsible professional exercise in the health field, also becomes a condition/element for the constitution of professional identity. This broadens the potential of bioethics - and the teaching of ethics and bioethics - from a tool for handling problems and dilemmas of practice, essentially aimed at promoting moral reasoning in decision-making processes, to tools that make a worker think that he/she is qualified for action, differentiates him/herself from others, and recognizes in him/herself certain attributes, logics, and values.[60]

This broadening of focus must precede the subsequent narrowing of that same focus when one wants to elect or prioritize a component or strategy integral to this complex process of formation. Only after giving light to this understanding can one arrive at the teaching of moral deliberation itself.

The first focus goes from the process of ethical-moral training to professional training and from this to the teaching of ethics and bioethics, that is, a "zoom" is given on a specific moment and scenario (university training), even recognizing that the proposals of this work apply to other scenarios where the moments of professional training are multiplied and expanded, by permanent education. The second focus is to zoom in on the teaching of moral deliberation, considering its importance in the

development of reflexive, dialogical, argumentative, and critical competencies, inherent to qualified and responsible decision making.

The health care professional needs to have pertinent knowledge in order to manage the delivery of care for which he or she is responsible.[21] However, it is common for the ethical dimension of their work to be neglected or overlooked, due to the pressures of time and routine, leading to a greater appreciation of the answer itself than the methods used to produce it, calling into question the possibility of reflecting and deliberating on the daily work.[54,61]

Recognizing the importance of offering space for ethical/bioethical reflection in the training of health professionals implies overcoming traditional teaching-learning modes, which are limited to the transmission of definitions, themes and codes/standards, not promoting dialogue, the exchange of knowledge and perspectives.[62-63]

Deliberation is not only resolute, but also educational. Deliberative dialogue favors mutual learning between teachers-discents-teams, sharing of experiences, motivation, sense of belonging,[49] contributing to qualify teaching in discussions about public problems, evidence-based interventions, course changes, among others.[50]

Given this potential, there are initiatives to study and experiment with innovative and appropriate methods for such learning, both in academic training and in the continuing education of professionals. Hence, problematizing, participative, active, and reflective strategies and methods must be continuously improved and socialized. The methodology adopted passes, necessarily, through the valorization of practical experience as a source of knowledge and object of analysis, and of dialog as an opening to the other, a condition for the enrichment of moral perspectives (dialogical ethics).[63]

Although Diego Gracia's theoretical and methodological contribution is highlighted in this work, it should be recognized that other authors have applied Moral Case Deliberation in professional health practice, aiming to improve the moral competence of professionals and the quality of care.[61-62,64-67] Contents necessary for Moral Case Deliberation (MCD) to promote moral reasoning are pointed out, including theoretical mastery of moral reasoning (principle-based and relationship-oriented ethics), definitions and facts about the patient's psychosocial situation, solutions to the problem (concrete actions for the patient's situation and the institution), and pointers for the MCD approach process itself.[68]

A study on the application of Moral Case Deliberation highlights that most participants perceive the relevance of applying this methodology to their daily work, which contributes to the quality of the dialogue in a positive way. Also manifested is the increase in moral sensitivity and the effectiveness of communication, decreasing prejudices and automatic responses.[65]

The goals of the discussion in the Moral Case Deliberation are mainly to reflect on the case to analyze what it means to be a good professional and to improve the quality of care, as well as to broaden the moral competencies of the participants.[61,66]

It is worth noting the Brazilian study[69] in which elements of a methodological framework were developed for moral deliberation and or systematization of the analysis of complaints and ethical-professional processes in Nursing, built from the analytical framework of the speeches expressed in ethical-professional nursing processes. This reference suggests application in the evaluation of ethical complaints and in the procedures involving the deliberation of ethical processes. It represents a generic proposition, which requires adaptations according to the situation of the complaint or ethical process, or according to the institutional decision instance. Broadening the application context, it is possible to propose this model for several practical applications, such as in educational settings.[69]

By highlighting the plurality of authors and contributions, we reaffirm the potential of creative applications, faithful to the purposes of the methods and their conceptual bases, whether such applications are directed to solving moral problems in clinical practice and ethics/bioethics committees, or to problematizing everyday situations involving professional practice, or to promoting in students reflection, sensitivity, and skills to address and confront moral problems.

It is because of this very openness to methodological proposals, aligned with solidary perspectives, that it becomes coherent to assume the multidimensionality of social reality and of the subjects' perspectives, and to seek greater support in narrativism, for the educational task of fostering the plurality of thoughts and mental abilities, of enriching and "opening minds" to what is different.[39:167]

It is believed that the formation of ethical and moral competencies through deliberation and narrativism, for its coherence with active and problematizing methods - in this work exemplified by simulated teaching - have great potential in professional training in health, and should be strategically developed.

2

REFERENTIAL MATRIX FOR THE SIMULATED TEACHING OF MORAL DELIBERATION AND APPROACH TO ETHICAL PROBLEMS IN HEALTH TRAINING

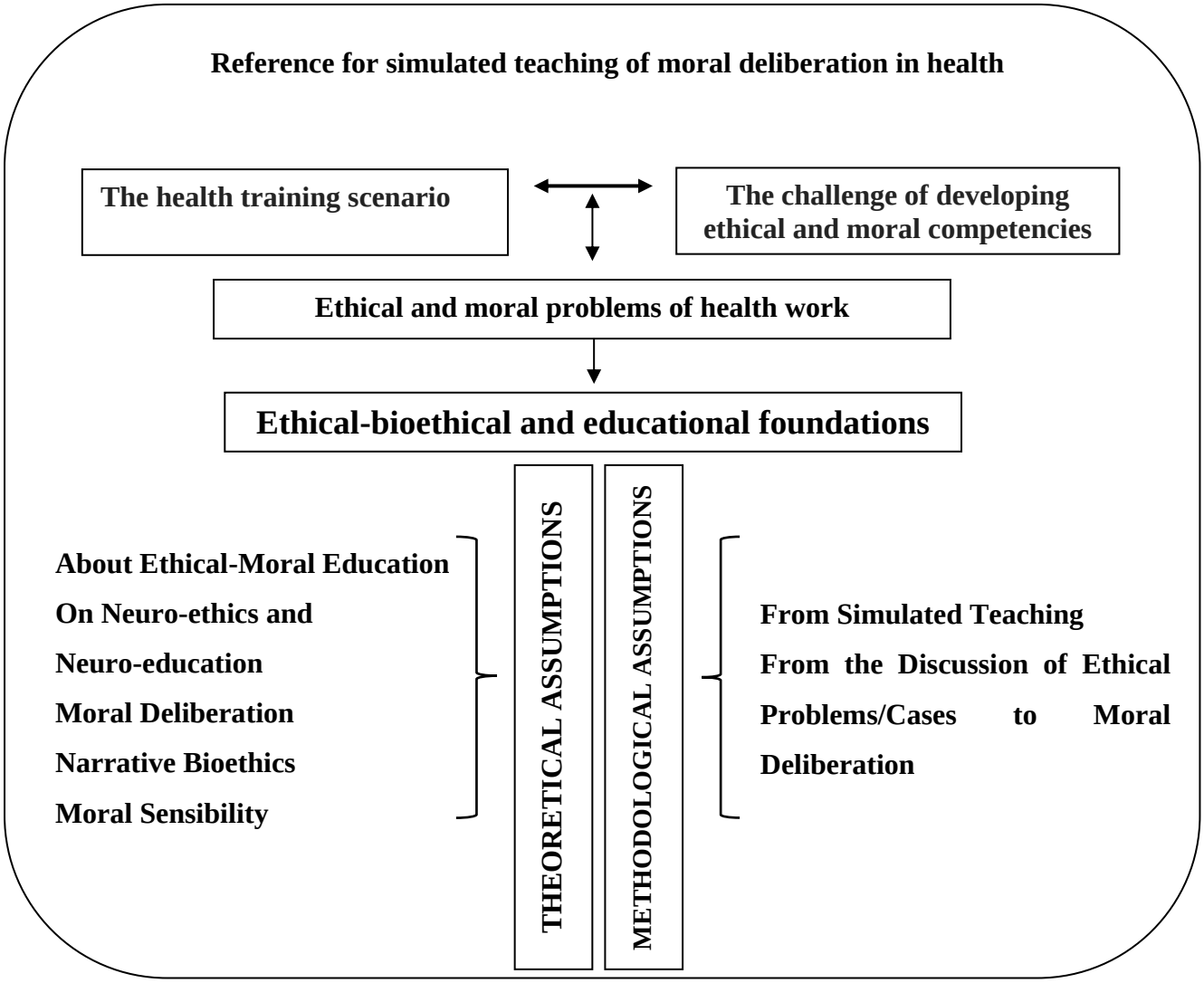
Flávia Regina Souza Ramos, Dulcinéia Ghizoni Schneider

This work was built to respond to the challenge of ethical-moral education, articulating concepts and references that are useful in the proposition of pedagogical tools. From the referential presented so far, we summarize the assumptions that can support such a task, in this or in different practical propositions.

From the elected bases, presented in the previous topic, it is possible to synthesize the positions taken, or the basic assumptions that guide the proposition of educational strategies. It is worth saying that no way to develop an educational action is free from conceptions and intentions, explicit or implicit. It is important to emphasize that each author/teacher/user of a method or strategy can and should seek the foundations that will best give coherence and consistency to his practices, or even critically reflect on the conceptions and theoretical bases that underlie proposals that are presented or imposed in "packages".

What is done here is to explain our way of understanding and capturing the set of ideas of the different authors synthetically addressed, constituting a singular appropriation of them, in the form of assumptions that support the most practical propositions. It does not mean the only, the most correct or complete way to translate and apply these conceptual bases, but only a possible reading and articulation of different contributions, cited throughout chapter 1. The important thing is that other readings can be made, in the permanent exercise of improving educational practices that are aimed at ethical and moral formation. In this way, this Matrix should be used as a suggestion for new appropriations, reformulations and adaptations that interest and apply to the specific educational context. The fundamental thing is to note the importance of this stage of clarification of concepts, principles and values that one wishes to put into practice in the pedagogical experience, without which it becomes subject to the simple application of ready-made formulas and fads.

In general, the path of this construction can be summarized in the scheme below.



Theoretical assumptions

Ethical and Moral Training [D]

In professional health practices, moral competencies are required to act responsibly in the face of the complexity of human life and suffering, of inter-professional relationships, of conflicts and uncertainties in scientific, technical, and institutional fields.

[D] Inspired by the authors: Hardingham, 2004[4]; Lützén, Cronqvist, Magnusson, Andersson, 2003[5]; Oguisso; Schmidt; Freitas, 2007[6]; Bordignon et al, 2011[8]; Lang, 2008[10], Sporrong, Höglund, Arnetz, 2006[11]; Nathaniel, 2006[12]; Ferreira; Ramos, 2006[13]; Ramos et al, 2013[14].

The ethical and moral formation of the health professional articulates sociocultural processes throughout life, also integrating the various experiences of professional education, which participate in the construction of professional identities.

The teaching of moral deliberation should be assumed by educators and educational institutions as a fundamental part of professional training, based on ethical and bioethical precepts compatible with the responsibilities of the professional field and its contribution to civility and culture.

From Neuro-ethics and Neuro-education [E]

The understanding of moral conduct as socially and culturally elaborated can be convergent with the knowledge of its intrinsic basis (neurological, genetic, and intuitive) in order to support educational processes aimed at ethical-moral formation.

The brain/mind/person needs interaction to make sense of social situations and, therefore, cooperative activities and active methodologies are capable of stimulating interaction, motivation and engagement, and are not limited to auxiliary resources for information processing and memorization.

From Moral Deliberation [F]

Moral deliberation is an educational process, which operates in a systematized and contextualized itinerary, improving moral competencies, dialogue, mediation, and the quality of resolute judgments.

Moral deliberation relies on a collective commitment to creating solutions, optimizing skills and knowledge, in an environment of respect, safety, and maturity.

Narrative Bioethics [G]

Narrative bioethics is critical and self-critical, fostering moral experience in contexts of relationships and responsibilities and embodying the world of values in concrete expressions of the complexity and diversity of human life.

[E] Inspired by the authors: Cortina, 2018[22]; Cortina, 2010[24]; Felip, 2015[25]; Béjar, 2014[26]; Rodgers, 2015[27]; Tokuhama-Espinosa, 2008[28]; Zaro et al., 2010[29]; Bebeau, Rest, & Narvaez, 1999[31]; Rest & Narvaez, 1994[32]; Moll et al, 2007[33]; Han, 2017[30]; Tachibana 2017[34]; Tachibana 2017[35].

[F] Inspired by the authors: Gracia, 2001[46]; Gracia, 2002[47]; Gracia, 2014[52]; Loch, 2008[44]; Zoboli, 2013[45]; Dalla Nora, Zoboli, Vieira, 2015[49]; Acosta, Oelke, Lima, 2017[50]; Schaefer; Vieira, 2015[51]; Legault, 2014[55]; Legault, 2016[48].

[G] Inspired by the authors: Moratalla, 2016[36]; Moratalla, 2014[39]; Feito Grande, 2016[37]; Almazán García, 2017[38]; Manchola, 2017[40]; Manchola, 2014[42]; Lima, Cambra, 2013[41]; Stein, 2016[43].

Narrative bioethics is a way of doing bioethics and a perspective or way of seeing realities and problems, providing narration as a sensitive access to the other and to oneself, and thus fighting the depersonalization of care processes.

Narrativity stimulates problematization, imagination, and creativity, and is a valuable resource in the process of ethical formation and the construction of moral competencies.

Of Moral Sensibility [H]

Moral Sensitivity constitutes a central element (intellectual dimension) for the perception and understanding of professionals about ethical problems and the promotion of moral behavior.

Moral sensitivity is closely related to moral reasoning, since the professional must know his code of ethics, the legislation of the professional practice and possible conflicts that may occur, to recognize them and identify what is the right thing to do, preserving the health, safety and rights of the patient.

Moral ethics education expands human sensitivity, which in turn will increase the ability to perceive the moral dimensions involved in problematic situations, enabling the person for the process of moral deliberation, developing skills to act morally.

Methodological assumptions

From Simulated Teaching for Moral Deliberation and Addressing Ethical Problems in Health Care Training [I]

The simulated teaching as a strategy in the development of competencies in health training, enables the creation of a realistic environment, with well-defined steps that facilitate the active participation of the student in the relationship between theory and practice, reflection and action, making it possible to apply the knowledge learned in a controlled environment, allowing repetition and evaluation in the debriefing stage.

[H] Inspired by the authors: Lützén, Dahlqvist, Eriksson, Norberg, 2006[15]; Comrie, 2012[16]; Dalla Nora, Zoboli, Vieira, 2017[9]; Borhani et al, 2015[2]; Tuvesson, Lützén, 2016[20]; Park, Kjervik, Crandell, Oermann, 2012[19].

[I] Inspired by the authors: Oliveira, Massaroli, Martini, Rodrigues, 2018[70]; Bland, Topping, Wood, 2011[71]; Neves; Pazin-Filho, 2018[72]; Fabri et al, 2017[73]; Zoboli, 2013[45].

The simulated teaching of moral deliberation provides the approach to ethical problems inherent to professional practice in a realistic situation, contributing to learning from team discussion, dialogue that respects other points of view, opening a range of possibilities for courses of action, preventing the problem from becoming a dilemma.

The simulated teaching of moral deliberation offers the possibility for the student to reflect on what he would do in theory (idealization) and what he actually does (simulation), mobilizing knowledge and feelings. The moral deliberation method organizes, directs, and contributes to the reflection on the possibilities of decision making in the approach to ethical problems in health education.

From Discussing Ethical Problems/Cases to Moral Deliberation [J]

The starting point for deliberation is a concrete case or situation that mobilizes or demands a moral deliberation, in which a moral issue is identified, that must be adequately formulated, shared by the participants, recognizing those affected by the problem, their values and the interests involved.

The formulation of the case or moral problem to be addressed should have reference to the reality of health training practices and scenarios, incorporating the plurality of views on the problem, of potential concepts and values that support reflection, of alternatives for action, and of tangible consequences.

The group of people, students and professionals, functions as a deliberative group, and should express autonomy, commitment, responsibility, and knowledge; be heterogeneous, broad in knowledge and perspectives.

The dynamics and group should be conducted in a flexible, balanced, tolerant way; avoiding anxieties, insecurities, intimidation and frustrations, since it requires diversity of skills and involvement.

The facilitator or mediator of the argumentative-deliberative process, not influenced by professional hierarchy, must be able to work with power relations and

[J] Inspired by authors who approach the process of moral deliberation from the perspective of clinical bioethics, such as the referential of Diego Gracia[46], or the "Moral Case Deliberation" methodology (Tan, ter Meulen, Molewik et al, 2018[67]; Svantesson, Silénm, James, 2017[68]; Molewijk et al, 2008[62]; Molewijk et al, 2008[64]; Molewijk et al, 2008[65]; Plantinga el al, 2012[66]; van Der Dam et al, 2011[61]; van Der Dan et al, 2013[54]; Molewijk; Kleinlugtenbelt; Widdershoven, 2011[53]).

emotions, ensure listening to different perspectives, and promote open and constructive moral dialogue, supporting joint reasoning and action planning.

The educational moment, simulation or deliberative session requires preparation, a favorable environment and time for the development of all the stages and reflections.

Openness to creativity, imagination and dialogue should direct the choice of additional resources, which broaden the focus from the description of the case to the development of sensitivity, articulating the rational and affective dimensions, through artistic and symbolic representation in the educational task.

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PART 2

3

MORAL DELIBERATION: METHOD FOR A BIOETHICS OF RESPONSIBILITY

Mirelle Finkler

> […] bioethics is due to the need that civil society feels to reflect and deliberate on the problems related to the management of the environment, of the bodies and lives of present human beings, and of our duties toward future generations. It can no longer be doctors, nor politicians, nor economists, nor priests or theologians who have the monopoly of decision making on these kinds of issues. It must be the whole of society that deliberates and decides on them. Only in this way will we achieve what we all consider indispensable, the glimpse of a new, more human world; that is, of a new culture.[1:39]

We are participants in democracy and therefore co-responsible for it: this is the foundation for an ethical education. Such participation requires an understanding of human values and deliberative decision-making competence in pluralistic societies such as ours. Hence, education is crucial for a democratic citizenship, and should nurture public discourse and the engagement of civil society for the common good. To this end, it requires, in addition to knowledge, ethical awareness, critical reflection, and commitment to action.[2]

Given the challenges of the advance of science and technology, the persistence of historical humanitarian problems, and the current rise of authoritarianism in several countries around the world, deliberation is an important tool for responsible decision-making in societies that claim to be democratic and that strive for civil and citizen ethics.

In Brazil, during the first decades of the Unified Health System, the possibilities of professional participation have expanded, for example, in health councils and research ethics committees. Collective ethical deliberation started to be required as a new professional excellence, necessary for the ethical improvement of health practices.[3]

In this context, one can state that "deliberation is a school of life (...) and (that) bioethics courses should be true schools of deliberation".[4:13] But to what deliberation are we precisely referring?

Pose[5:88] warns us that "it is usual to identify deliberation as a simple dialogue, or to believe that it is about helping to make decisions by consensus. This is a big mistake". In fact, the word "deliberation" is described in the Portuguese dictionary as "action or effect of deliberating or deliberating oneself"; as "argument on a controversial

subject", synonymous with "debate"; "discussion whose purpose is the resolution of a problem"; and yet, "act performed or resolution made after reflection".[6] In this way, it is a term widely used and has several meanings in common sense, in the political, legal and philosophical spheres.

From a philological perspective, deliberation comes from the Latin deliberative, which derives from the root liber. Libertas meant a state of absence of coercion. From this it follows that deliberation depends on freedom to make decisions, whether this freedom is external (absence of coercion) or internal (absence of ignorance, incontinence or inauthenticity). One deliberates, therefore, in order to act autonomously. Liber also formed the expression *liberum arbitrium*, meaning weight, that is, a measure that one puts on the scales to contrast with other elements. A term that suggests, then, the weighing between different factors and the choice of the option that arises among them.[5]

In bioethics, deliberation obviously occupies a central space, but also in this area it is necessary to identify what kind of deliberation is meant. The U.S. Presidential Commission for the Study of Bioethical Issues, for example, proposes "democratic deliberation" as a method of decision-making in which participants discuss and debate an issue of collective concern, with the goal of reaching an actionable decision by policy or law. To this end, they propose the following as steps in the democratic deliberative process: begin with an open-ended policy question; dedicate time for deliberation with maximum impact; invite subject matter experts and the general public to participate; promote open discussion and debate; and develop detailed recommendations for action.[2]

In the bioethical literature, moral deliberation is revealed as a means and instrument for systematizing the management of ethical problems. It promotes the continuing education of professionals through the development of ethical competence that involves knowledge, sensitivity, and critical and dialogical skills for the analysis and prudent resolution of moral conflicts in health. Its concept has been anchored in different authors, and so have the methods for structuring the deliberative process.[7]

Regardless of affiliation, deliberation has been attributed a number of contributions to health care work. Individually, they mention a comprehensive and in-depth approach to users and ethical situations; awareness, recognition, discernment, and critical reflection on ethical problems; decreased frustration and distress with relief of

moral suffering; security to handle ethical problems; assistance in finding answers to them; as well as development of moral competence. From the perspective of multidisciplinary health teams, the contributions of the method are mentioned as understanding and cooperation among professionals; strengthening dialogue; favoring the educational process and inter-professional learning; creating an environment of reciprocity, solidarity, and empathy with room for sharing experiences; work motivation; feeling of belonging to the team; usefulness in daily life; and improvement in the quality of care. It is, therefore, a method capable of promoting the humanization of health care.[7]

In this text, we approach moral deliberation from Diego Gracia's theoretical-philosophical conception and methodical proposal[4] that rescues it from Socrates[K] and especially Aristotle, who introduced and systematized it[L]. Despite the classical origin[M], it is an approach in Ethics that only in the 20th century, after the crisis of pure reason and the revaluation of feelings in moral life, began to attract the attention of philosophers because of its reach, now very different from the traditional.[5]

This option is anchored in the wide dissemination of the method, which has been successfully employed in institutional, clinical care and research ethics committees for nearly four decades[8] (I); in our formative and deliberative pedagogy experiences in higher health education [9] (II); in the recognition of its practical-instrumental value and in the appreciation of its theoretical foundation (III) that, differently from other bioethical - deontological or utilitarian - references, is not attached to certain morals, thus opening space to a truly plural dialogue.

Diego Gracia's bioethics of responsibility

> The history of 20th century ethics is the discovery of a new criterion for moral action: that of responsibility for the future. Never before has the

[K] In Socrates, deliberation had the structure of a dialogue, consisting of a method of evaluating one's own ideas and beliefs with the help of others (the so-called "maieutics") in order to discover the limits of wisdom.[10].

[L] We owe to Aristotle "the recognition that there are different classes of sciences (theoretical, practical and productive), different types of knowledge (scientific or demonstrative and opinionated or probabilistic), different types of argumentative languages (apodictic, dialectical, rhetorical and sophistical) and, consequently, different methods (deductive and deliberative) and different degrees of truth (certainty and prudence).[10:74].

[M] From a historical perspective, the origin of deliberation was political. The Greek term for deliberation was boúlesis, a noun linked to another name - Boulé - which was the Council of Elders in ancient Greece: a forum for public pondering and counseling, formed by men of wisdom gained from experience, the so-called "prudents" (phronimoi).[5:65]

> history of ethics given human beings this idea of responsibility. This is responsibility toward the future; the other, responsibility for the past and the present had already been part, in one way or another, of moral consciousness. What is new now is that responsibility is fundamentally for the future, for what is technically possible we do not know whether it should be ethically.[10:172]

Diego Gracia Guillén - philosopher, physician, clinical psychologist, psychiatrist and educator - is the greatest exponent of bioethics in Spain, and one of the most influential bioethicists in the world, thanks to his philosophical and clinical background, as well as his knowledge of medical history and medical anthropology. Recognized for his rigorous intellectual work, his philosophical studies and the foundation of his bioethics are closely linked to the philosophy of Xavier Zubiri and the thought of Pedro Laín Entralgo, of whom he was a disciple.[11]

The maturing of his work in bioethics went through different phases, of which the most current version stands out, which justifies the insufficiency of the language of principles and consequences - typical of the Anglo-Saxon world - and the inadequacy of the language of duties and rights - typical of the Germanic world - as languages proper to ethics. Substituting the classical language of virtues for the more modern language of values, his "Deliberative Bioethics "[12] has, as its central axis, axiology[N] of life - bioethics as construction and realization of values,[13] as the foundation of moral judgments, an ethics of responsibility[O], and as a method, moral deliberation.[10]

Diego Gracia's "Bioethics of Responsibility" has three fundamental characteristics: I. Globality, because it considers dignity a moral quality of all; because it takes bioethics as the first attempt to think ethics in a global way; and because it advocates for an ecological bioethics; II. Its autonomy from religions, laws, and technology, and III. Its prudential and deliberative character. Thus, its production - from clinical bioethics to global bioethics - has been structuring a theoretical and practical

[N] The reader interested in developing the method of moral deliberation is strongly recommended to read "GRACIA, D. La cuestión del valor. Real Academia de Ciencias Morales y Politicas: Madrid, 2011. 203p. In particular, the second part of the book, where the author deals with the world of moral values, the relationship between values and ethics, and moral education or ethical training programs.

[O] The ethics of responsibility was born at the beginning of the 20th century in the context of existentialism. It tried to answer the proper moral question (what should we do?) considering that it was no longer appropriate to look back, toward universal principles or a priori duties, but ahead, toward our projects, toward the future, since the essence of the human being must be constructed, which is freedom. Thus, the human being must solve his moral problem autonomously and bear the consequences of his own decision. Hence, it is an ethics of responsibility, and bioethics - which emerged in the third part of this century as a concrete movement within the more general movement of the ethics of responsibility - is a bioethics of responsibility.[5:103-104]

framework that has significantly contributed to decision making in the field of life, intending to collaborate with a new model of democracy - a deliberative democracy.[10] Understanding that bioethics is in essence deliberation, he considers that it can guide such a transformation,[1] from moral judgments grounded in a secular, plural, autonomous, reasonable and responsible perspective.[10]

As the author explains, morality is constitutive of the human being, because it is a natural need, a biological phenomenon on which our survival depends. And this is because, unlike animals subjected to the law of "natural selection," human beings do not adapt to the environment, but rather value everything and everyone around them, projecting actions toward their future. From this capacity of estimation or valuation, he transforms the natural world into a cultural world, by adding values to it. It lives, therefore, under the law of "moral choice". It is precisely because of their capacity and need to project everything to which they attributes value to, that they are, necessarily, a moral being. More than just carrying out projects or actions, the human being needs to justify them, to ground them, for them and for others, because their projects and actions are accountable to them, even before they are carried out. This accountability is usually called responsibility or justification. We need to justify what we want to do or what we do in front of our moral conscience.[14]

From our links with others and with reality derive our obligations, and from these derive our duties and responsibilities. This is the basis of the experience of duty that is our moral experience.[15] Values demand their realization. In other words, they demand to become reality, to take shape, to become incarnate. This is why we feel that they oblige us to do certain things and not to do others. And this is why promoting the best values is our ethical duty.[12,15] Ethics is about finding out what our moral duties are and does so by analyzing the facts and values present in moral conflicts.

> A conflict is a very determined thing. It is not the same, for example, a conflict as a problem. The term problem comes from the Greek *próblema*, which in turn derives from the verb *pro-bállo*, which means to launch forward, to put forward,*pró-pôr*. Life is a problem, because we have to be continually "*pró-jetando*", choosing among the different alternatives that present themselves in each situation. To choose is always a problem […] a problem is not a conflict. The problem arises from the need we have to choose between different possible courses of action. Conflict, on the contrary, consists of the clash between two or more things.[16:231-232]

There are conflicts of facts, conflicts of values, and conflicts of duties; and also so-called "moral conflicts". Facts are data of perception. They are forceful and

definitive, so that in common language we use this word to express the sense of something indisputable. Facts are perceived directly or indirectly, immediately or through instruments. But there are things in life that are not data of perception or facts: they are the values. Unlike facts, values are not perceived, but estimated, appreciated, valued. This is an important distinction between perception and valuation: perceiving the same, we can value differently. Another important point is that without facts there are no values. Values are distinct from facts, but depend on them. This means to say that facts are the support of values or that values are supported by facts.[15]

The world of values is a very rich one, but we are almost illiterate in it. Although values are what is most important in our lives, and that to value is an essential function, we do not know how to talk about them and even less how to manage them in situations of conflicts of values. Incompatibility between values presents itself when, in the attempt to realize them, the promotion of one prevents the total or partial realization of the other.[13,16]

In the human being, besides the world of facts and the world of values, there is also a world of duties. We differ about the content of our duties, but the experience of duty is practically universal. And as said before, what we owe is to realize values - peace, justice, freedom, love, solidarity, beauty, truth and so many more. These ideals impose themselves on reality, making us feel obliged to realize them. In the same way that values are built on facts, duties are built on values. That is, values support, ground and justify our duties.[13,16]

Our values only come into conflict when we move from the second to the third world, that is, when we move from Axiology to Ethics. It means that a conflict of values is, in reality, a conflict in the realization of values. And being so, they are, in the strictest of terms, conflicts of duties. These conflicts can be of two levels, moments or dimensions. The first of these refers to the level of the ideal, where circumstances are not considered. It would be, therefore, the moment of the "should", that is, of the realization of pure, ideal values. The second level is the realization of value in concrete cases, where the circumstances are proper and known. It would be, in this case, the moment of the "should", of the realization of values in the reality under analysis. This difference between what one should (prima facie duties) and what one ought (actual duties) is what is called a conflict of duties. Moral conflicts, therefore, are conflicts of values as well as conflicts of duties.[13,16]

To solve them it is first necessary to understand their logic. Unlike mathematical problems that usually have a solution and, moreover, have a unique solution that can be demonstrated to be true, almost all the other problems of the world have a different logic. Moral judgments are rational, but they are not apodictic. They are dialectical, that is, they deal with the logic of opinion[P]. Opinions are rational judgments that also involve non-rational elements such as beliefs, feelings, and values. Our opinions do not exhaust the analysis of problems, allowing different and even opposite judgments that may also be true. Thus, it is the polyvalent logic of probability, not the true/false logic.[16-17]

Health decisions are often problematic precisely because they carry within them some degree of uncertainty. Being a competent health professional includes knowing how to properly manage this uncertainty, knowing that we can act prudently even if our decisions are only probably right. In the realm of clinical facts, we are used to using typical clinical methods to define diagnoses, prognoses, and treatments, reducing uncertainty and insecurity to reasonable limits. This is very important, because insecurity fosters irrational and unwise decisions, besides causing some degree of suffering. It happens that in the clinical field, as in any other, there are no pure facts, because, as I said, the values of the people who analyze them are always built upon the facts. And in the world of values we still have difficulties, especially in situations of moral conflicts.[14]

In these situations we are seized by anguish, which triggers defense mechanisms such as *denial* - not listening or considering the other as an interlocutor; *aggression* - imposing one's own point of view by coercion or coercion; *projection*, which tries to end the anguish by looking for a culprit; and *rationalization*, which locates unreal or incorrect reasons to justify or impose one's own points of view, or to exclude others from decision making.[14] All, forms of action that reinforce the paternalistic model of clinical relationship, contrary to the emancipatory model.[5]

Our emotions lead us to extreme positions, of total acceptance or total rejection, and convert moral conflicts into dilemmas, that is, reduce them to issues with only two possible ways out - extreme, incompatible, and irreducible. The dilematization

[P]Apodictic logic is derived from theoretical reasoning. It is demonstrative, convincing, and does not admit contradiction. It demonstrates the conclusion from the premises, ensuring its truth, without the possibility of an alternative or a different result. Dialectical logic, on the other hand, is that of practical reasoning, where at least one of the premises is an opinion. It is the logic proper to the moral sphere.[4:136]

of a moral conflict is usually the result of anguish.[16] But moral conflicts need not be understood as dilemmas. This is only one of the possible positions, and not by chance, precisely the one that counts with the largest bibliography in medical literature and that is more present in the mass media. Faced with this dilemmatic posture or decisionist or technocratic mentality, the objective of ethics would be to give arguments that tip the scales of moral judgment more to one side or the other, based on probability and preferences or values[Q]. The dilemma stance assumes that there is one correct decision to be made and only one.[17] In bioethical discussion, this reduction of the possibilities for action to only two antagonistic positions has been called the "dilemmatic fallacy"[R].[18]

A decision on a moral conflict is only optimal when all the clashing values can be saved, at least to some extent. This requires the search for intermediate solutions, which are usually not easily perceived, because our natural tendency is to argue by imposing our point of view and trying to convince others of our arguments. It is human nature to want to be right. More than this: to want to be absolutely right.[14] To deal with uncertainty while controlling anguish we must follow a method that tells us how to analyze a question and make a decision: the method of deliberation.[19]

This deliberation requires the problematization of moral conflicts, not their dilematization. Problems are open questions that we do not know whether we can solve. Their solutions are not given in advance, but need to be created. Problematization takes for granted that reality is always more complex than any possible theory or idea, or, to put it another way, that there is an inevitable mismatch between reality and our reasoning. Such a mismatch is evident in practice, in political, ethical and technical issues. In these issues certainty is impossible and only probability can be achieved. Thus, ethical reasoning would not be that of episteme/science, but of doxa/opinion. This means that opinions are uncertain, but not irrational.[19] Understanding this differentiation between decision mentality (which focuses on decision making) and problem mentality

[Q] Based on the Utility Theory, whose ethical version is Utilitarianism, it assumes the idea of maximization of preferential results, taking utility as the main ethical criterion. This dilemmatic mentality is also present today in many convinced deontologists, due to the fact that they think that moral questions can be solved exactly and that there is only one correct answer that would be universal and absolute, that would be discovered by the direct and deductive application of principles and norms.

[R] The dilemmatic fallacy is also present in civil society debates. It can be observed when participants defend ideological positions that polarize the dialogue, hindering the search for consensual solutions, which end up being defined on the basis of votes or reduced to the legal perspective, delivered to someone who has expertise in the matter. This is the core of the dilemmatic fallacy, characterized as rhetorical, because it lures the argument and makes discussion impossible.[18:198]

(which focuses on engagement in the deliberative process) is essential in Diego Gracia's proposal.[20]

Collective deliberation is not something natural, but moral, something we can learn. However, it is a difficult learning process that requires as a starting point, the assumption that no one possesses the whole truth and that the other, thinking differently, can enrich our perspective of analysis. Thus, deliberation is only possible through psychological and emotional self-control that reveals itself in the form of practical behaviors that facilitate deliberation, namely: willingness to dialogue; capacity to listen and desire to understand the points of view of others; and a certain amount of humility.[16,19] For all this, deliberation is a sign of psychological maturity. Only he who is able to control the feelings of fear and anguish can be whole and have the presence of mind that the method requires.[16]

We all deliberate individually before taking a decision, so that it is prudent, responsible. We do not deliberate on what is obvious or on what can be demonstrated, because what can be demonstrated is demonstrated, is proven, dispensing with deliberation. While demonstration gives absolute certainty, deliberation gives prudence for decisions about which it is not possible to speak of certainties.[14]

Moral deliberation is thus the technical procedure that helps us find the intermediate courses of action that are usually the most prudent. It can be individual, but since concrete reality is always richer than our intellectual schemes, we must add other points of view to our own, especially when the problems are complex and/or affect many people.[19] All those affected by the consequences of decisions are valid moral agents[21] and should ideally participate in its deliberative process. When this is not possible, it is necessary to take them into account, so that the decision can be morally acceptable to them.[14]

The result of deliberation is always in the difference between the starting and the ending point, with respect to the broadening of our perspectives on the deliberated ethical problem. An adequate deliberative process is one that allows us to better see the solution to the problem - the optimal solution - only at its end. In some cases, the members of a deliberation group will not achieve consensus on the final solution to the deliberate case, but the articulation of their reasons will change everyone's perception of the problem. This is their great learning. Hence, the deliberative process is, above all, a powerful tool of ethical education for a global and democratic society.[19,21]

The method of moral deliberation proposed by Diego Gracia

As seen above, the interconnection between facts, values, and duties is fundamental in the construction of moral judgments that occurs in deliberation. It follows that the deliberative procedure occurs on three levels: deliberation on facts, deliberation on values, and deliberation on duties.[19] Its itinerary can be seen in chart 1.

Chart 1 – Stages of the moral deliberation method. Source: Gracia[16]

Deliberation of the facts

1. *Case Presentation*
2. *Clarification of facts*

Deliberation on values

3. *Identifying ethical issues*
4. *Election of the ethical problem to be deliberated*
5. *Identification of conflicting values*

Deliberation on duties

6. *Identification of possible courses of action*
   a. Identification of extreme courses of action
   b. Identification of intermediate courses of action
   c. Identify the optimal course of action
7. *Evidence of consistency of the decision*
   a. Proof of legality
   b. Proof of advertising
   c. Proof of temporality
8. *Decision-making*

The demand for the deliberative process arises from a person's need to make a decision about what to do about a particular ethical problem. Thus, the case presentation must be made by the one with the problem.[16] This presentation must be planned in advance, so that all information relevant to the assessment of the case is included. If the case is related to a patient or a disease, for example, the clinical situation, diagnosis, prognosis, and treatment must be presented. It is important that such planning be done in writing and in detail, trying to reduce as much as possible all uncertainties. Aspects related to social, family, cultural, educational, and religious conditions are usually necessary to understand the moral aspects of the problem20 and should be detailed as much as possible.

After the presentation of the case, the participants in the deliberative session should ask the person who presented the case anything they still think they need to

know to better understand it. The clarification of facts should exhaust the doubts of the participants, covering all related aspects. Many of the errors in moral judgments are due to a poor analysis of the facts. Thus, a good deliberation on the facts is fundamental for a good moral deliberation. That is why it is the role of the moderator to stimulate questions from the participants and to allow sufficient time for this step. The best way to know when to end it is to pay attention to redundancies, that is, arguments that start to repeat themselves without introducing new perspectives of analysis.[16] Occasionally it may happen that the presenter is unable to answer important questions about the facts, and it is advisable to postpone the deliberation so that such answers can first be obtained.

Our experience in the teaching-learning of moral deliberation shows that the participants' lack of experience with the method and/or lack of maturity causes questions to emerge at this stage that are not restricted to the facts, as if they were trying to anticipate possible solutions. Faced with this situation, it is up to the moderator-teacher to explain the importance of each deliberative level being carried out at its due time and in full. It may also be pedagogically interesting to take this opportunity to clarify what the facts are (distinguishing them from courses of action, for example) and identify the feelings that the method arouses, alerting to the importance of emotional development for its success.

Once the deliberation on facts is finished, we move on to the deliberation on values. The moderator should then stimulate the participants to identify the ethical problems related to the case. Here the term "problem" is intentionally used with all its ambiguity. An ethical problem will be anything that for someone, intuitively, is an ethical problem. In this way, we seek to break the participants' initial fear of speaking out. The important thing is that all those who believe they have identified some ethical problem say so. The greatest difficulty in this stage, however, is not in the difficulty of identifying them, but in communicating them. We are able to express ourselves accurately in the things that happen in the world of facts, but we have difficulty in doing so in the realm of values. This leads people to try to verbalize the problems identified with long and imprecise explanations. Ideally, instead, they should be communicated as precisely and succinctly as possible. Since these are problems, it is appropriate to formulate them as questions. And since they are ethical problems, the verb in the sentence should preferably be the verb "should".[16]

At this stage, the moderator should list, on a board visible to all, the ethical problems that are being communicated in the form of questions (Figure 1). For the teaching-learning of the method, it may be important that the moderator-teacher encourages the members to express the problems they have identified, and even helps them by rephrasing more imprecise questions. Although the method does not prescribe a certain number of problems to be listed in each case, experience shows that it should never be less than seven. As in the fact-finding stage, one strategy for knowing if it is time to move on to the next stage is to watch for redundant problems.

Figure 1 – List for identifying ethical issues in the 3rd step of the deliberative method

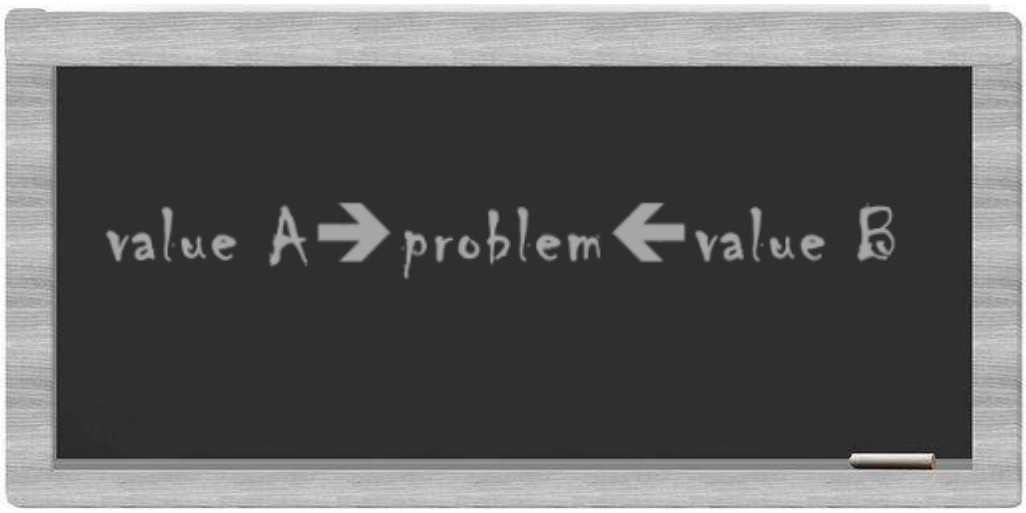
Identifying and communicating ethical problems are skills to be trained. In doing so, we increase our ethical sensitivity, improve our ability to understand and express moral problems, and enrich our perspective by listening attentively to others. Such actions, besides contributing to the moral education of each participant, are important for the further steps of the method. If it is not done this way, in the further analysis each one may be referring to a different ethical problem, making it impossible to reach a solution. Therefore, one must choose the ethical problem to be deliberated.

This choice should be made by the person who presented the case, that is, by the person who proposed the deliberation because he/she needs advice to solve a specific problem. She should not actively participate in the previous step, but rather the different members of the deliberative group. Once the list of ethical problems is finalized, the person should be asked if the problem that concerns her is among those identified. If it is, you should indicate it, and if it is not, you should add your ethical

problem to the list, which will be, from then on, the object of the deliberative analysis. Experience with the method shows that the proper analysis of just one problem takes no less than two hours, and that therefore a deliberation session can only handle the analysis of a single problem.[16]

In the last stage of the deliberation of values, it is necessary to identify the conflicting values, that is, to transform the ethical problem into a moral conflict, moving from the concrete language of problems to the abstract language of values.[16] To do this, it is useful to delete the list of problems identified in step 3, leaving only the ethical problem that will be deliberated. The aim is then to collectively identify which values are clashing in the concrete case (Figure 2).

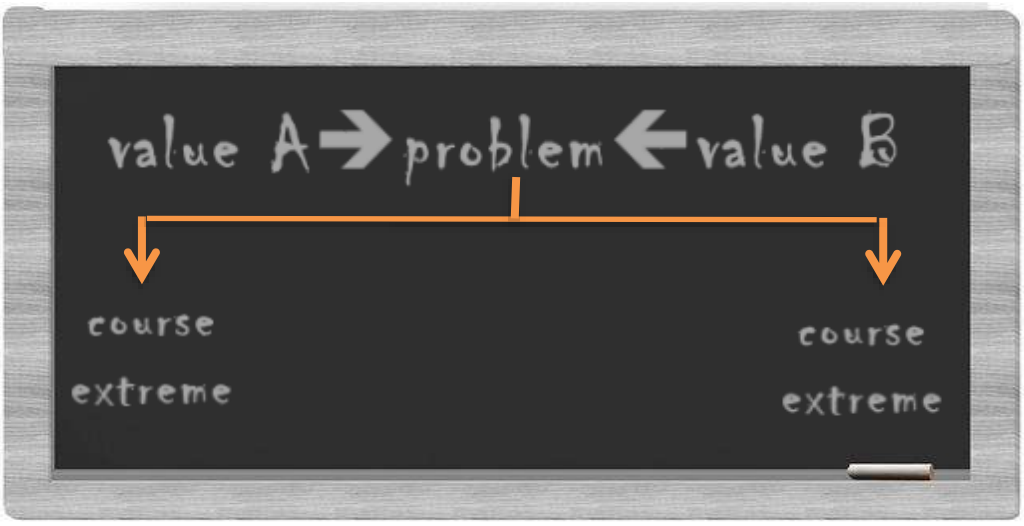
Figure 2 - Identification of the conflicting values in the 5th step of the deliberative method



"An ill-defined conflict of values compromises the rest of the deliberative process, because the essence of the case is lost [...] [therefore] requires double attention".[20:56] This is one of the most difficult steps for people inexperienced in the method, but as they deliberate, the values start to become more easily identifiable. A frequent mistake is to indicate a positive value and its opposite - a negative value, because in this case there would be no conflict and deliberation would be unnecessary. In the classroom, this step can also be important to increase understanding about what moral values are and what they are, distinguishing them, for example, from ethical principles.

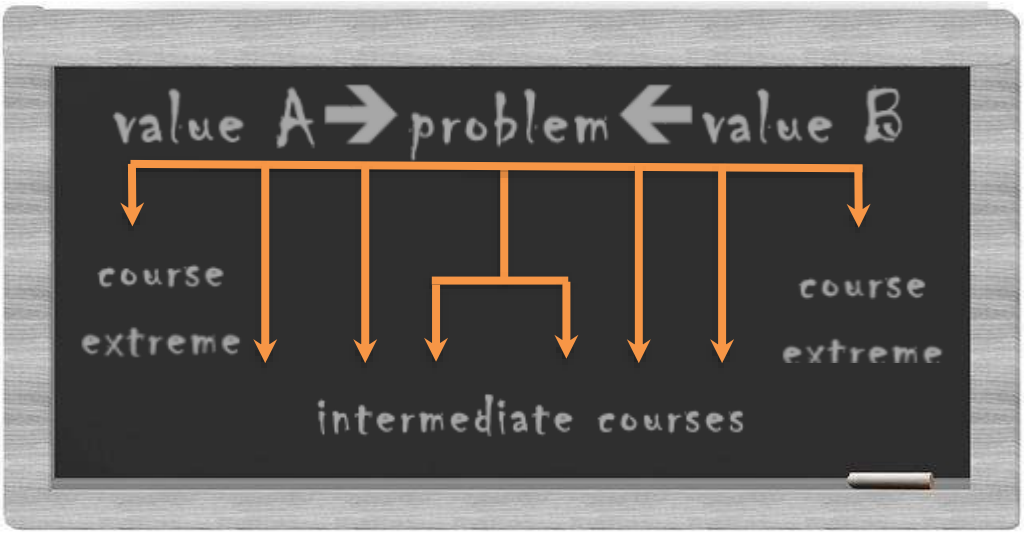
The deliberation of duties begins, then, with the identification of possible courses of action. Courses of action are the possible outcomes in a given situation. The human mind tends to reduce courses of action to two, opposite to each other, as if we see black and white, but not all the shades of gray in between. Given this propensity, we start by identifying the extreme courses of action (Figure 3). We already know beforehand that they are usually drastically damaging to values, but it is important to identify them. The truly extreme courses always consist of the same thing: if you choose one of the values, you annihilate the other. This is why they are tragic, imprudent and should be avoided. They should not be chosen as a final decision unless all intermediate courses have failed.[16] Thus, they must always be considered as extraordinary, exceptional solutions.[20:56]

Figure 3 - Identification of extreme courses of action in the 6th step of the deliberative method



The next step consists in identifying intermediate courses of action (Figure 4), starting from the extremes and moving towards the center, where the most prudent solution usually lies, thus evidencing the problematic rationality that underlies the deliberation.[20] This task depends on time and imagination, and is optimized by the presence of group members with diverse backgrounds and experiences, who enrich the analysis and increase the number and quality of outputs. It can be taken as a rule that the possible courses are always five or more, and that if fewer were identified, the analysis process was flawed.[16]

Figure 4 - Identification of intermediate courses of action in the 6th step of the deliberative method



After identifying the extreme and intermediate courses of action, it is necessary to deliberate on the optimal course of action, the one that maximally realizes each of the conflicting values or harms them as little as possible. It is the search for the most prudent and responsible decision, which can only be defined after weighing all the circumstances.[16] Often the optimal course is composed of more than one intermediate course of action, as a set of measures that can be taken in the case. It is also often the case that there is consensus about the optimal course of action, even though this is not the goal of the method.

Although at this point in the procedure an optimal course has already been defined, prudence requires us to test it. To do so, it must be submitted to certain tests of the decision's consistency. The most important are: the legality test - is the decision legal?; the publicity test - would you be willing to make the same decision if it were made public?[16]

The legality test aims to ensure that the decision is not illegal. Ethics and Law are different things, so that a decision can be moral and illegal, or the opposite, immoral and legal. The method does not take laws into consideration until the end of the process, precisely so as not to confuse the ethical and legal analysis. But at this point in the analysis it is important to consider what the laws say about the optimal course; first, because it is unwise to give advice contrary to the law, and second, because if the optimal decision is illegal, the person being advised should be aware of it. The publicity test is important because one cannot be sure that the decision will not become public or

reach the courts. So if one does not feel able to justify the decision publicly, one should also rethink it. And finally, the temporality test, which is based on the fact that heated decisions made under strong emotions are often unwise. The passage of time reduces our emotions, increasing the prudence of our moral judgments. So this test is about whether we are making a decision driven by emotions, or whether we would make the same decision if we could wait a few hours or days.[16]

If a decision stands up to this evidence, we can consider it prudent and advise it as a final decision to the person who presented the case. It will be up to him to make the decision, since the deliberative process is neither executive nor decisive, but only advisory, and deliberation sessions do not relieve people of their responsibilities.[16,19]

The deliberation session coordinator is advised to be aware of the time that each of the steps will require. An appropriate distribution of time among the steps of a two-hour deliberative session is presented in Chart 2.

Chart 2 - Distribution of time among the activities related to the method's steps.

Time (min)	Activities related to the method steps
10	Presentation of the participants
10	Presentation of the case
25	Clarification of facts
20	Identification of ethical problems
5	Identification of conflicting values
5	Identification of extreme courses
30	Identification of intermediate courses
5	Election of the optimal course
5	Decision consistency tests
5	Decision making

Adapted from Gracia[4:49]

Further recommendations to the session coordinator, coming from the method proposer's years of experience in conducting deliberative sessions, can be found in Chart 3.

Chart 3 - Guidelines for the coordinator of the moral deliberation session.

The deliberation session coordinator SHOULD:

- To be experienced in the method, because it is necessary to master this skill in order to successfully conduct the process
- Have a background appropriate to the case and sufficient technical knowledge of the facts
- Conduct the sessions with appropriately sized groups (ideally with 12 people), because in larger groups there will be insufficient time for everyone to participate, and because in smaller groups, the diversity/richness of perspectives may be threatened
- Control the time and give everyone the floor, avoiding cross talk or very long speeches;
- Encourage the initial participation, a moment when the participants are usually still shy, taking advantage of the speech of those who initiate (care must be taken not to allow the most participatory people to monopolize the debate, especially those who feel gratified by the coordinator during his first intervention)
- Consider a subject exhausted and move on to another when the speeches start to repeat themselves without adding new arguments, always justifying why to consider that point closed and move on to the next
- Rescue the purpose of the session whenever opinions are too scattered or the debate deviates, emphasizing the need to focus attention on one point
- Justify why not to go back to previous steps of the process when a participant makes a pertinent statement about one of those steps
- Be very attentive to demand respect when there is any kind of conflict among the participants
- Be aware that your role is to coordinate, not to manipulate or direct, which is easier when you do not expose your point of view
- Try your best not to impose yourself
- Rotate the conduction of the sessions among the participants once they are well trained in its dynamics, so that they have the possibility to develop this skill
- Optionally, use an observer from among the participants, who has the function of exempting himself from the deliberation to make a critical analysis of the session at its end

Adapt from Gracia[4:50]

It is true that one learns to deliberate by deliberating, but it is equally true that the quality of deliberation will depend on the knowledge and experience of the session coordinator. In this sense, we recommend the direct reading of the materials referenced in this text, particularly those of Professor Diego Gracia, for a better understanding of his Bioethics of Responsibility. In addition, we suggest consulting the "commented clinical cases" that make up a specific section of the Complutense Bioethics journal[S], which since 2010 publishes reports of moral deliberation sessions, being an important source of real cases, especially useful for teaching-learning the method.

To conclude, we take up again Gracia's words,[16:259] for who...

[S] Available in: https://www.ucm.es/hc/bioetica-complutense.

> […] learning to deliberate leads one to know oneself a little better and to respect others more. The great tragedy of our time lies, as I see it, in this, in the very scarce capacity for deliberation. Instead of teaching to deliberate already in elementary school, we are trained in the opposite, in imposing our own point of view, in dogmatizing our statements, in opting for the extreme courses. That is why bioethics has today, at the beginning of the 21st century, a social function of the first order, to promote deliberation, not only in the health field, but in society as a whole.

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4
CLINICAL SIMULATION AS A TEACHING METHOD

Saionara Nunes de Oliveira, Marina Silva Sanes, Jussara Gue Martini

Conceptions about simulation

Simulation, in its genuine meaning, is an imitation of reality. It is simulated through games, art, training for war, aviation, and also in health education. In health, simulation helps in the development of care provided to people, groups and communities, with greater mastery of knowledge, skill and attitude; a care that must necessarily be offered in a competent, ethical, and high quality manner.

Clinical simulation is the recreation of a situation of everyday health care, selected to develop specific skills listed by the teacher, guided by the teaching plan of the subject or course in question. Strongly influenced by aviation, which has used systematic flight training programs since 1930, simulation has been incorporated into education, for at least three decades.[1]

Gaba[2] states that simulation is a technique and not a technology. This means that it is not the technological apparatus that determines the use or not of simulation, but how it is applied in the ways of teaching, regardless of the resources used for this purpose. Merhy[3] contributes by presenting a more comprehensive technology classification that incorporates both equipment (hard technology) and processes (soft-hard technology) and relationships (soft technology). Based on this definition, clinical simulation can be classified as a soft technology, since it is a form of teaching with well-defined stages and is not limited to the use of the simulator.

One study analyzed different concepts attributed to simulation and presented a definition that encompasses all others, which is clinical simulation as:

> [...] a dynamic process involving the creation of a hypothetical opportunity that incorporates an authentic representation of reality, facilitating active student participation and integrating the complexities of practical and theoretical learning with opportunities for repetition, feedback, evaluation, and reflection.[4:668]

The experiential learning theory, in this case, is one of the most widely used when it comes to clinical simulation. This theory, developed by David Kolb,[5] presents learning as the result of reflection on lived experience. Kolb's cycle predicts that the individual, who experiences a concrete experience and can observe it reflexively, can

theorize about this experience and re-signify it, in order to modify his or her future practice. This process, known as the Experiential Learning Cycle, supports and dialogues with the pedagogical assumptions that anchor the use of clinical simulation in the teaching of the health professions, both in initial training, as well as in permanent and continuing training processes.[5]

Given this, the objectives of this chapter are to reflect on the use of clinical simulation as a teaching method in nursing, considering the process of choosing clinical simulation, the elements involved in planning the simulation experience, the teaching and student roles in clinical simulation, and the ethical implications in the use of this tool.

The chapter is organized from triggering questions that can help readers in the journey of approaching the text, which is intended to serve more as a bridge of dialogues on the theme than as a simulation mode-text. Based on the experiences of the authors, stitched together with the available literature, it is hoped that the organization of the ideas presented here can offer learning and creative conditions for those interested in the theme.

Use of simulation in nursing

Nursing has always used simulation to teach its care techniques, whether through an orange for the application of injections or with the use of demonstrations between colleagues, of positioning in bed, application of bandages, or even using mannequins, initially made of cloth and currently called patient simulators, marketed for this purpose.

What used to be just a way to illustrate theoretical knowledge, allowing the visualization of its steps, is now gaining more and more space in academic environments, aiming to increase patient safety, opportunities for clinical experiences and reflective learning.

The International Nursing Association for Clinical Simulation and Learning (INACSL)[6] developed the INACSL Best Practice Standards, based on scientific evidence, which aim to provide better learning to deliver more effective patient care. They are organized into 11 criteria: (Chart 1)

Chart 1 - International Nursing Association Best Practice Standards for Clinical Simulation and Learning (INACSL, 2016)[6]

International Nursing Association Best Practice Standards for Clinical Simulation and Learning (INACSL, 2016)[6]
1. Conduct a needs assessment to provide the fundamental evidence of the need for a well-designed simulation-based experience.
2. Build measurable goals.
3. Structure the format of a simulation based on purpose, theory, and modality for the simulation-based experience.
4. Create a scenario or case to provide the context for the simulation-based experience.
5. Use various types of fidelity to create the necessary perception of realism.
6. Maintain a facilitative approach that is participant-centered and guided by the objectives, participant's knowledge or experience level, and the expected results.
7. Start simulation-based experiments with a pre-learning (briefing).
8. Follow simulation-based experiments with a debriefing and/or feedback session.
9. Include an evaluation of the participants, facilitators, the simulation-based experience, the facility, and the support staff.
10. Provide preparation materials and resources to promote participants' ability to meet the objectives and achieve the expected outcomes of the simulation-based experience.
11. Pilot test simulation-based experiments before full implementation.

Source: International Nursing Association for Clinical Simulation and Learning (2016)6 (our translation)

Why use clinical simulation?

Increasingly, clinical simulation has been gaining ground in the training of health professionals due to advances in the area of patient safety, the rights of users of health services, the legal responsibility of centers for training human resources in health and, more recently, the idea of safe learning environments.

From the perspective of knowledge construction, according to Miller's Pyramid[7], knowledge is organized in a hierarchical model of four levels: Knowing, Knowing How, Showing How, and Doing. Show how" is an important step for health care professionals who must be able to care for real patients with a sufficient level of theoretical and practical grounding. Simulation guarantees this learning space that unites theoretical knowledge (knowing) with a clinical situation (knowing how) and a need for action (showing how) for a safe clinical practice (doing).[7]

On the practical-conceptual side of Patient Safety, the literature documents the significant number of deaths resulting from errors committed by health professionals, from the report "*To Err is Human: Building a Safer Health System*" of the *National Academy of Sciences*, published in the year 2000, having as one of the strategies for

error reduction the use of simulation.[8] In a recent study with nursing students, authors identified simulation as an opportune time to review future preventable errors, which contributes to increased patient safety[9]

Clinical simulation allows events that require complex actions such as decision making, which requires ethics, professional responsibility, and the activation of emotional and psychological resources to take place in a safe learning space, whose experience allows for "the emotional preparation of future nurses, because by allowing students to practice their skills in safe environments, feelings such as anxiety and stress can be worked through and better learning achieved".[10:1030]

Although the history of Brazilian nursing itself has demonstrated, since its inception in the early twentieth century, the use of simulators and an a priori concern with the patient, there was not necessarily an explicit/conscious concern with the student. Since then, the advance in studies on simulation and its use as a teaching method has been adding both patient safety and the provision of a safe environment for learning.

Where to start?

Mapping the needs for the proper development of a simulation process that considers the standards described above and contemplates a logical structure in the teaching-learning process seems to be one of the biggest challenges for teachers and instructors, because it implies being clear about the reason for adopting clinical simulation as a teaching method. At this initial moment, it is necessary to consider some dimensions that can help the people and/or groups that are leading this process.

The pedagogical dimension is one of the perspectives that should be better planned and structured because it deals with the pedagogical intentionality that the teacher places on the use of clinical simulation. Gómez[11] when reflecting on the new ways of learning in contemporary education addresses the encouragement of methodological plurality. It is about considering that one teaching method does not respond in its entirety to any learning objectives and in any situations, and that it is therefore necessary to take into account the range of methodological possibilities for different learners, scenarios and types of knowledge. Perhaps herein lies one of the riches of the use of simulation: the decision that this is indeed the tool that best meets

the pedagogical intent in working with the development of competencies among participants in a simulation experience.

The other dimension considered essential for this moment is the operational dimension, when the availability of human, material and logistical resources is assessed. Here it is relevant to reflect on how the clinical simulation will demand actions from other sectors of the institution, such as purchase of materials for the scenario, including simulators, search for actors when necessary, and physical space. These elements are important when the objective is to portray something very close to the real thing. For example, how do you run a scenario on a hospital bed in the classroom? How accurate is this scenario? Or how many support people does the teacher have to organize the scenario, moving furniture, hospital instruments and nursing supplies? Is there a laboratory available? Questions such as the ones below can help in this initial moment. (Chart 2)

Chart 2 - Pedagogical and operational dimensions of clinical simulation.

Thinking about the pedagogical dimension of the use of clinical simulation	**Thinking about the operational dimension of the use of clinical simulation**
What competencies do you want to develop? Why is clinical simulation the best method for developing such competence? Who is the intended audience for clinical simulation? Should all students rotate/enter the scenario?	What is the number of faculty involved? What is the number of participants/groups involved? What is the availability of physical space (lab, simulation center, on-site)? Is there support staff for running the simulation scenario (audio and video assistant, computer technician, lab assistant), considering assembly, recording, use of simulators, etc.?

Source: The authors.

It is understood, therefore, that thinking about the pedagogical and operational dimensions before proceeding with the planning, organization, and realization of clinical simulation can be defining in the execution of the next activities. This does not mean that the clinical simulation can only happen if all these elements are available. Thinking about the dimensions, more than having these or those conditions, means being clear about the demands of the process, increasing the comfort of the teaching instructor in its use and avoiding unpleasant surprises in the course of the activities. After all, the goal is for "the simulation experience to be as believable as possible, keeping the participant immersed for as long as possible and, in turn, increasing the enjoyment of the activity.".[12:8]

Moreover, it is understood that gathering the necessary information in systematized records seems to help teachers, instructors and participants in understanding clinical simulation, being a resource for consultation whenever necessary, with the continuous possibility of improvement. Amaya Afanador[13] in text about the importance of clinical simulation guides describes this document as a faculty intellectual product:

> Clinical simulation guides can be defined as the didactic tools used in clinical simulation, the product of an academic consensus of professors who unify criteria to generate clear concepts, with scientific, group and institutional identity, to respond to a sense of professional training based on an educational project with its own identity that responds to the curricular needs currently demanded by the resolution of individual, social and cultural health problems.[13:310]

The clinical guides, from this reading, are documents that should contain a detail of the activities that occur before the simulation, during its development in the scenario and after this stage, gathering information so that the teacher can have quick, easy access to all the elements developed for the clinical simulation experience.[14]

What are the steps for organizing clinical simulation?

The first step when one intends to apply the clinical simulation method in health education is to define which competencies one intends to develop and if this method is really the most appropriate to develop them. Often, it is decided to use clinical simulation a priori, without considering the competencies one wishes to achieve, and one runs the risk of investing time and resources in creating clinical scenarios and all the structure that a clinical simulation requires and even then not achieving success in the educational proposal. The acquisition of technical skills, for example, is more successful with repetitive training followed by feedback than in the execution of scenarios, which should be used to develop decision making skills, teamwork, clinical reasoning.

Once simulation has been defined as the best method for achieving the desired competencies, the second step is to define general and specific learning objectives. The general objectives are related to the purpose of the experience, while the specific ones are related to the participants' performance measures. For example: Providing care for a patient with decompensated heart failure (DHF) comprises a general objective, which

students should have access to. Identifying signs and symptoms of dyspnea, one of the main symptoms of the patient with DHF, would be one of the specific objectives that the teacher would be assessing of this participant in this context. Only the teacher would be aware of this specific objective.

Neves and Pazin-Filho[12] advocate for the importance of the construction of learning objectives, defending the idea that this moment involves the composition of the curricular content to be addressed, who the participants are, and what they are expected to accomplish. For example, if the audiences are undergraduate nursing students, it is expected that at the end of the scenario, they will be able to make decisions based on the knowledge built up to that moment. In the case of health professionals in training to update their work process, the learning objectives will be different. That is, the same theme may require a different design for the learning objectives according to the target audience.

Once the objectives have been defined, the next step is to construct the clinical situations, or clinical scenarios, that best represent the real contexts in which the clinical competencies can be applied. Where will the scenario take place? In an emergency room, on a ward, at the patient's home? Who will be the characters in this scenario? Patient, family member, companion, multi-professional team? What is the clinical situation presented or context for the scenario to start? What happens to the patient that requires the nurse to act?

Fabri and collaborators contribute that this moment should be structured in "the best levels of evidence available, and not only justified by the trainers' personal experiences, which strengthens the students' confidence".[15:5] Moreover, the better the case description (this does not mean an excess of detail), including patient documents, medical records, exams, "the less chance there is that information provided at the last minute interferes with the credibility of the scenario".[12:5]

Once this script has been built, it is necessary to define the material resources needed to put the planned clinical situation into practice. Simulators, simulated participants (actors), *moulage* (makeup and props to make the scene more realistic, such as artificial blood, stomas, hematomas, etc.) can be used. If the simulation is filmed, in order to use the images at the moment of discussion, it is necessary to think about cameras, microphones, speakers, televisions or projectors. In addition to this equipment, the whole scenario must be set up seeking to achieve the simulation's fidelity, making it

as realistic as possible. In this sense, you can use your creativity trying to approximate the laboratory's appearance to the real context that you intend to simulate. It is important that the materials necessary for the performance of the care are present in the scenario and that it is not necessary to "imagine" that they exist, or that they work.

In addition to material resources, it is necessary to have human resources. A scenario requires time control, camera handling, replacement of materials on the set for the next group, organization of groups and previous orientation, careful observation of the scene, and debriefing. Depending on the number of participants and the time available for the activity, more teachers or technical assistants may be needed.

The participants of clinical simulation, students or professionals, should be made aware of this teaching and learning method beforehand. Knowing its stages and the formative learning objectives, in which the error is just one element that will lead to reflection and significant learning, without punishment or exposure.[14]

The theoretical content should be worked out in advance, offering elements for the participants' actions based on the best scientific evidence. This means that participants, when entering a simulation experience, must have already had activities that meet the learning objectives of less complex domains such as knowing, identifying, relating, and already be prepared to develop more complex learning objectives such as analyzing, creating, and evaluating. In addition, the choice of theme must dialogue with the real and authentic needs experienced in health services, which requires systematic planning and attention in the creation process.[15]

The pre-briefing or briefing is the moment before the scene where the teacher clarifies questions about the scenario, presents the simulator and its features, duration and closing of the simulation, i.e., it is the stage of presentation of the rules of the game. At this moment the fiction contract is also signed, an agreement that is made to ensure a more effective immersion in the scenario. The student must consider as truth some aspects that are not so realistic in the scenario, such as the time that will pass more quickly between an action and the patient's evolution, the presence of gases that are fictitious, among others. This means that there is an agreement to suspend the disbelief that the scenario is not real, agreeing that the simulation is true and the participants are cognitively involved in the real clinical situation.[16]

Also in the briefing, the teacher contextualizes the clinical situation so that the participant can start acting, for example: "You are the nurse in the medical clinic

admission unit and you are admitting a patient with clinical situation X, perform the anamnesis of this patient and identify the main nursing problems presented. You have x minutes for this activity, when you are ready you can start".

During the scenario, the teacher's focus is to identify the elements that may help the discussion in order to promote reflection and thus generate lasting learning. The teacher looks for situations that can be explored in the debriefing in order to understand how the student elaborated his line of reasoning for decision making and thus correct or improve this ability, so that in similar situations, the student can retrieve these assertive connections for more efficient decision making. Thus, the scenario experience must be able to provide the participant with a faithful cognitive, psychomotor, and affect experience that is able to advance the participant's experiential knowledge construction for application in real clinical scenarios.[15]

The debriefing is then the moment of becoming aware of what was done, why it was done, and how it could be done. The student becomes the protagonist of these reflections, and it is up to the teacher to guide the student with questions and provocations that stimulate curiosity and promote discussion and the collaborative construction of new knowledge. Boostel and collaborators[10:1035] explore simulation as a process that improves the "perception of stressors related to lack of competence and interpersonal relationship to act in front of the patient, the multi-professional team and colleagues in comparison to the conventional practical class in a skills laboratory".

Without wishing to prescribe ways of doing so, this is a methodology that is theoretically and conceptually composed of complex constructs (autonomy, decision making, reflection, responsibility), which requires the involvement of all participants in the simulation experience, especially the teacher and/or simulation instructor in its conduct. Although many of the elements are clearly defined, the teacher's self-critical and pedagogical view should accompany the entire planning process, as it is an educational, relational process, a meeting between learning subjects. Therefore, it is a process that is always in the process of becoming, never given and dated, given the richness of human nature inherent in the educational act.

What are the roles and responsibilities of faculty and participants in clinical simulation?

Revisiting the literature and from experience with colleagues, professors, and students, one realizes how common it is to have questions about the roles of faculty, participants, and actors. Many need to visit simulation centers, talk to course coordinators and professors, and watch simulations to understand the organization and distribution of roles and responsibilities of each person involved.

Given this, we aimed to gather data from the specialized literature on health simulation with information about pedagogical processes to share some considerations about how the activities developed by teachers and participants are understood.

Having already addressed the key elements for clinical simulation in a previous moment and proceeded to a more detailed discussion, here the relationship of teaching and student activities in the teaching-learning process using clinical simulation as a pedagogical tool is presented (Chart 3). This is the operationalization of the key elements and moments of the simulation in their relationship with the activities of each participant.

Chart 3 - Relationship between teaching and student activities in the teaching-learning process, using clinical simulation as a pedagogical tool

Relationship of teaching and student activities in the teaching-learning process, using clinical simulation as a pedagogical tool			
Identifying stages/moments of the SM	**Key Elements for Clinical Simulation**	**Professor**	**Participant**
Pre-simulation	Learning Objectives	Designs the general and specific learning objectives	Knows the general learning objectives
	Theme	Selects/selects within the possibilities of the curricular unit which topic best helps in the development of the designed learning objective	Develops and knows (studies/learns)
	Clinical situation	Constructs the clinical situation in a way that expands the learning possibilities by dialoguing as closely as possible with reality. Often uses his/her professional clinical experience in the creation of the clinical situations	Participates in the teaching-learning process on the subject
		Prepares the participant during the teaching-learning process, offering theoretical (classes,	Participates in the teaching-learning process in classes,

	Students preparation	seminars, case studies, etc.) and theoretical-practical (skills training) learning conditions about the topic to be worked on in clinical simulation	seminars, case studies, skills training, and assessments on the theme to be worked on in clinical simulation
Actual Clinical Simulation	Briefing	Describes the case, providing contextual, clinical, social elements, among others, that are fundamental to the approach to the scenario Presents information that is really necessary for the beginning of the scenario (there are elements that the participant will get to know during the course of the scenario) Performs the fiction contract with the participant, a moment in which agreements are agreed upon for the adequate progress of the scenario, considering that not all the elements of a scenario may be rigorously simulated (for example, a screen that divides two environments may be agreed to be a wall between two rooms within a health service)	Receives the clinical situation presented by the teacher, answering questions regarding the scenario, available materials, and any action to be taken Performs the fiction contract
	Scenario	Observes (pedagogical look) the participant in contact with the scenario, as well as the skills, knowledge and attitudes presented in the scenario shooting It is considered a data collection moment for the teacher, because the elements collected here will be relevant for the debriefing	Experiences the scenario, applies the theoretical knowledge built, uses/activates skills and competencies, makes decisions
	Debriefing	Allows the participant to describe what happened in the scenario and what feelings were involved Stimulates the participant to relate what happened to previous moments (theory) of the teaching-learning process The teacher is a cognitive investigator17 and needs to understand how thinking was organized in that scenario (what made the participant act that way?)	Participates actively commenting what he/she experienced and felt in the scenario (describes both the sequence of activities, actions and events) and the associated feelings and emotions Reflects about the scenario, bringing together theoretical, theoretical-practical, professional and ethical elements Performs a self-analysis of your performance in the scenario

Source: The authors.

Professional, pedagogical and ethical implications in the use of clinical simulation

Considering that health care occurs mostly through a multidisciplinary practice, inter-professional education is an attribute that needs to be integrated into the initial and continuing education of health professionals. If professionals from different professions need to have/exercise a collaborative practice in health, it is essential to reflect on how they learn/could learn together. Thus, inter-professional education can be a possible learning key to qualify health care.[18]

From the complexity of health care it is understood that clinical simulation presents itself as a tool that allows these different professional experiences to be put under analysis, that is, clinical simulation can allow students from different professions to learn together about how to create a singular therapeutic project. Professionals in healthcare teams also benefit from clinical simulation by learning about new issues, by sharing decisions among team members. The richness in the use of clinical simulation with inter-professional education is also highlighted in the way students/professionals learn about each other's work, because they get to know each other's work.[18]

That said, it is essential to mention the ethical component and its relationship with clinical simulation as a pedagogical tool, whether in the academic field or used in ongoing training processes for health professionals. Having presented the elements that are involved in the design, construction, implementation and evaluation of this process, it is suggested to pay attention to some points, as a way to enrich the practice of clinical simulation, giving it the necessary dimension because it is an experience very close to the real thing.

Machin and colaborators[19] in a recent publication, reflections on how to plan ethically oriented inter-professional education are shared. This is a group of researchers from two universities in northern England who, problematizing the teaching of ethics through inter-professional education, have designed a practical guide that, dialogues with the interests of this chapter. The authors present key lessons for planning ethics-oriented inter-professional education that, read together with the available pedagogical literature, can be a source for qualifying the relationship between the constructs ethics and inter-professional education. It is thus understood that clinical simulation adds quality to the teaching-learning process of its participants when it is anchored in assertive pedagogical assumptions, committed to the end activity of the health area,

which is the provision of safer, responsible, harmless, professionally integrated and ethically oriented care.

Machin and collaborators [19] state that ethics and inter-professional education have the same objective and this coherence brings benefits by bringing the two themes together, in such a way that the theoretical and conceptual framework of ethics may be able to guide the practices of inter-professional education.

Thus, the same authors[19] consider the following key lessons for ethics-driven inter-professional education planning, which establishes well-established relationships with the clinical simulation being discussed here: the importance of planning in choosing the format, structure and theme of the activity; the clarity of the design of the participant's learning pathway in the activity; the timing of including this activity in the curriculum; the preparation of students for the activity; the creation of a safe learning space; the reflection on broader student learning; the emphasis on debriefing in addition to feedback, the involvement of health services professionals and even patients, the concern with offering an activity that is flexible and considers the preferences of students and groups.[19]

In this weaving, clinical simulation can also be understood as a tool guided by ethics, from its inclusion as a pedagogical element in the curriculum to the debriefing process, which has in the reflective process its great characteristic. And, considering that health care takes place mainly in inter-professional teams for a collaborative practice, simulation is also circumscribed as a space for the development of inter-professional skills, as it has enough elements for collective learning experiences (Chart 4).

Chart 4 - Relationships between ethics-driven inter-professional education and clinical simulation

Relationships between ethics-driven inter-professional education and clinical simulation		
Ethics-oriented interprofessional education	**Clinical simulation as a teaching method allows?**	**Elements**
Choice of activity format, structure and theme	Yes	Choice of Topic Creating the clinical situation
Clarity of the design of the participant's learning path in the activity	Yes	Learning Objective Design Participant's Learning Trail Student activities in the scenario
Timeliness of including this activity in the curriculum	Yes	Relationship of simulation with professional competence development
The preparation of the students	Yes	Theoretical preparation Briefing

Creating a safe learning space	Yes	Every process allows, as long as the proposal is known to all participants
Reflection on broader student learning	Yes	Focus on competence development Participant Learning Trail Debriefing
Emphasis on debriefing	Yes	Debriefing
Involvement of health care professionals and patients	Yes or partly	Professionals and patients in the scenario
Concern for offering an activity that is flexible	Yes	Each simulation is a unique process from the experiential learning point of view The pedagogical eye of the teacher
Participants' preferences	Yes	Participant's Learning Trail, using his own references Teacher is an investigator

Source: The authors.

Furthermore, simulation must be guided by a qualified professional who knows the methodological proposal in order to ensure that learning occurs in a planned manner, respecting ethical principles. The Society for Simulation in Healthcare (SSIH) published in 2018 the "Healthcare Simulationist Code of Ethics" that presents the following key values for the practice of simulation: Integrity, Transparency, Mutual Respect, Professionalism, Accountability, and Results Orientation.[20]

The code of ethics, initially written in English, is available for consultation on the SSIH website[20] and already has versions translated into other languages. This material guides the practice of the simulator (person who conducts the simulation) and makes us reflect on the ethical implications that permeate the use of this teaching method not only from the standpoint of patient safety, but also the psychologically safe environment for learning.

Thus, it is hoped that this chapter has been able to expand readers' references on the topic of clinical simulation as a teaching method in nursing, signaling it as a powerful tool that brings together characteristics capable of preparing future nurses for professional practice, as well as assisting in the development of reflective thinking. More than that, that teaching through clinical simulation is an ethical process involved with respect for the human being cared for and the human being learner.

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PART 3

5

GUIDE FOR CREATING AND APPLYING CASES OF MORAL DELIBERATION AND ADDRESSING ETHICAL PROBLEMS IN HEALTH TRAINING

Dulcinéia Ghizoni Schneider, Flávia Regina Souza Ramos

Objective:
- Guide the development of moral case deliberation (MCD) pertinent to specific needs
- Provide a guide to the application of moral deliberation cases

Just like the proposition of the Theoretical Framework (chapter 1), elaborated from the contribution of different authors, and the Matrix itself (chapter 2), intended to promote new appropriations, this Guide is also an example of a possible appropriation, or a way to operationalize and guide professionals and educators in their task of bringing theoretical bases to life in teaching activities.

The Guide itself does not maintain absolute fidelity to a single referential, although the grounding in Diego Gracia's process of moral deliberation is noteworthy[1-2] (discussed further in chapter 3). As also noted above, the use of deliberation of moral cases as a teaching method[T] has been studied and, although they do not reveal incompatibilities between different proposals, they do not indicate unified bases and strategies.

This situation, instead of being considered negative, is taken as a productive and creative moment in this field of concerns and productions, where philosophers, educators, bioethicists and health professionals circulate. It is precisely in the sense of contributing to the opening to new experiences and to more everyday problematizations that this Guide seeks to respond. It did not intend to tell "the cases" already reported and used, but to stimulate that the experience of the group (teachers, students and professionals) be approached in a systematized and consistent way, expanding the richness of the educational path, beyond the moment of "deliberating" (in itself rich in its stages), valuing the moments of preparing, imagining, narrating, creating, sharing and deliberating, in short, growing as a moral subject.

In the synthesis presented below in the "Preparatory and Application or Development Stages", the suggested actions take shape in applications that consider

[T] Referred to as MCD (Moral Case Deliberation), following the example of Tan, ter Meulen, Molewik et al, 2018[3]; Svantesson, Silénm, James, 2017[4]; Molewijk et al, 2008[5]; Molewijk et al, 2008[6]; Molewijk et al, 2008[7]; Plantinga el al, 2012[8]; van Der Dam et al, 2011[9]; van Der Dan et al, 2013[10]; Molewijk; Kleinlugtenbelt; Widdershoven, 2011[11].

"the cases" as resources to develop the process of deliberation for educational purposes and also as an exercise of creation, that is, an opportunity to problematize the experience and make it "a case" that mobilizes the group for reflection. For this reason, actions are presented in parallel that apply to the objective of elaborating new cases or applying cases of moral deliberation already constructed. Actions that are more useful in health teaching are also detailed, when steps such as "Practical strategies; Theoretical references and concepts that support the decision; and Relationship with the professional Code of Ethics (Nursing or others)" can be highlighted precisely for future professionals to appropriate aspects that in other spaces may be more stabilized and incorporated.

In this sense, the preparation of cases for the application of the method of moral deliberation in education needs to be supported by information that promotes discussion, reflection and rationale for the decision considered most appropriate/prudent in that circumstance, considering the context and the situation of those involved. The Guide aims to promote reflection, together with the students, in the creation of situations that stimulate moral sensitivity and promote the development of ethical and moral competence to act ethically in the face of moral problems that are involved in health care.

1 Preparatory stage

<table>
<tr><th>For MCD development</th><th>For the proposed MCD application</th></tr>
<tr><td colspan="2">1. <u>Recognize the participating PURPOSES and PEOPLE</u>: Are they professionals (one or several categories) or students? What is the background and experience of the group? Are they linked to an institution? Do they present a specific demand (around a common situation)?</td></tr>
<tr><td>2. <u>Select the FOCUS and CENTER THEME of the MDC to be elaborated</u>: Which real or fictional situation will be relevant? What elements of reality should be added (scenario, subjects, and specific problem)?</td><td>2. <u>Select the MCD to be used</u>: for its direct relevance to the demand or for its usefulness in mobilizing reflection</td></tr>
<tr><td>3. <u>Describe the CASE:</u> define the general case script from the situation data, people involved, scenario and context
<u>Survey in advance other COMPONENTS of the deliberative process:</u>
• conflicting values;
• people affected by the decision;
• alternatives or courses of action
• action/decision;
• consequences of each course of action
• wisest decision;</td><td>3. <u>Define adaptations, if necessary:</u> aspects of the description can be changed (e.g., by including characteristics specific to those involved, such as gender, social status, type of service, and so on)
ATTENTION: substantial changes involve reviewing the entire course of deliberation, because the proposed exercises are not closed, but limited to the aspects pointed out</td></tr>
</table>

• practical strategies; • theoretical references and concepts that underlie the decision; • relationship with the professional code of ethics **ATTENTION:** the previous survey of the components or stages is part of the preparation of the MCD, but does not close it, so that new reflections and points of view can be added by group reflection	
4. **Preparation of the CONDUCTOR-MEDIATOR:** teacher or professional who will lead the process of deliberation of the case, which implies previous reading and understanding of all parts and steps	
5. **REPROPRIATION (by the driver-mediator):** fundamental step, because MCD's can never be taken as final and perfect decisions - they are exemplary in the search for resolutions for the moment and the case. New looks, critical questions, and references should be stimulated	
6. **Set TIME, PLACE, AND RESOURCES:** it is important to have guaranteed the necessary time to carry out all the steps (even if divided into stages); an adequate, comfortable and private space (that allows the manifestation without embarrassment); resources and support may be necessary, according to the complementation of strategies (role-playing, simulation, discussion in subgroups, bibliography consultation, among others)	

2 Application or Development Stage

Heating and Collective Agreements

This is an important initial action in group practical exercises. The participants should agree on the rules of relationship and conduct of the activity, as an example (others can be agreed upon):

a) Respect the allotted time and the role of the mediator/driver;
b) Listen to the entire MCD description before starting the discussion;
c) Ask for the floor and wait for each person's turn to speak;
d) Avoid monopolizing the floor or insisting too much on your arguments - the ability to listen and respect the other person's position is part of the process;
e) Develop tolerance and cordiality.,

Case Description: situation/persons involved/scenario and context

Basic questions: What is the case? What is the problematic situation? It refers to the presentation of the case, in narrative language, inserting the group in the context of the problematic situation. Remember that usually one person is responsible for electing the course of action and is the one who brings the problem to the group (in Ethical or Bioethical Committees/Committees and as presented by Diego Gracia[1-2]). In the case of Nursing, and also in multi-professional teams, it is common to deal with decisions involving one or more professionals who share responsibilities.

Conflicting values

Basic questions: What values are involved? What conflicts of values are present?
It refers to the moment of clarification of values, that is, to highlight possible values that clash from the perspective of the different stakeholders, as well as to clarify possible hierarchizations or prioritizations of values (comparison, classification, and reasoning) and the basis for establishing such priorities.

People affected by the decision

Basic questions: Who will be affected by the decision?
Besides those directly affected, it is necessary to think about all those who will suffer any repercussions from the decision taken. In clinical situations or those involving health care and management, they can be users/caregivers, family members, communities or specific groups, services and institutions, professionals, among others.

Alternatives or courses of action/decision

Basic questions: What are the possible alternatives or courses of action/decision?
Various alternatives or decisions should be raised and discussed, avoiding eliminating in advance any possibility, regardless of whether it is unusual (to usual practice or to the experience and perspective of those involved) or questionable - questioning is important and should be promoted.

Consequences of each course of action

Basic questions: What are the consequences of each course of action?
Once the possible alternatives have been identified, they must be subject to detailed analysis, starting with the identification or prediction of the consequences that would be generated if they were applied. The consequences must be discussed, whether positive or negative, weighing the desirable, acceptable, or unacceptable effects, in light of the values/principles and the conditions of the subjects, considering vulnerabilities, inequalities, protections, and rights.

Wisest decision

Basic questions: What is the most prudent decision? Can this decision be made public?
The most prudent decision is the horizon, the desired outcome of the deliberative process. Prudent is the decision that realizes all conflicting values to the maximum, which is usually located in the middle courses and can only be defined after weighing all the circumstances. The prudent decision can always be put to the test and exposed to public knowledge, because it has been matured, impartial, does not fear scrutiny and is rationally defensible.[1-2,12]

Practical strategies

Basic questions: What strategies to put into practice?
Once the course of action has been chosen, it is necessary to clarify how it impacts the conduct of those involved, what the responsibilities are, or how the professionals will act so that the decided path can be materialized. What is the responsibility of each one? What are the next steps? What communications and developments need to be carried out?

Theoretical frameworks and concepts that underlie the decision

Basic questions: Which theoretical references support the decision?
Considering the educational purpose and the commitment to the continuous development of moral competencies, the concern with theoretical deepening is added to the purpose of problem solving or deliberation. Thus, it is necessary to break with simplistic and common sense visions, which usually link personal attributes for moral deliberation only to technical skills or experience. After the clarification of values and the definition of the most prudent decision, one must promote the continuity of studies and the search for readings and reflections that broaden the subjects' bases on the present case and on future cases. Concepts and principles discussed until the final stage should be revisited, in order to indicate bibliographies or research tasks for further clarification.

Relationship with the Professional Code of Ethics (Nursing or others)

Basic questions: Which articles of the professional code of ethics relate to the problem and the most prudent decision? Is there evidence of infraction in the professional action reported in the case? In which articles does the chosen alternative find grounds for its justification under the professional code of ethics? Were the principles expressed in the code respected or disrespected?
In the health field, the deliberative process involves regulated professions and professional practices that must respond to their own ethical regulations. That is why this step is important, especially because of the educational purpose of the process, so that it mobilizes not only knowledge about these regulations, but also critical reflection on them.

6

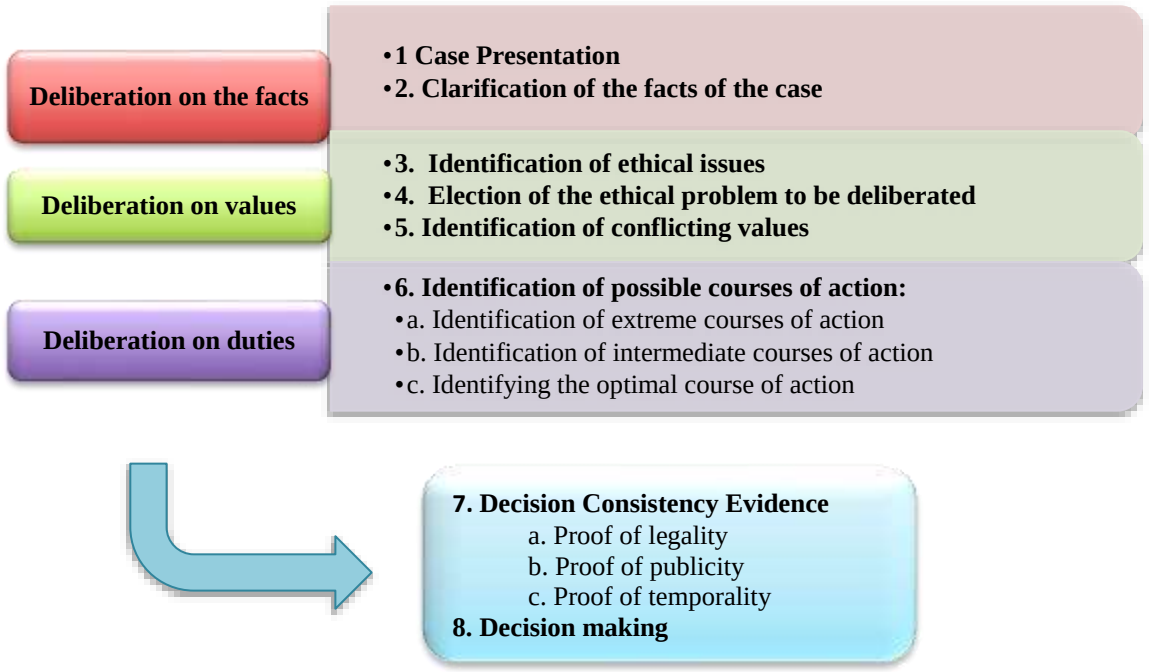
EXPERIENCE REPORT OF TEACHING MORAL DELIBERATION WITH SIMULATED CASE

Dulcinéia Ghizoni Schneider, Flávia Regina Souza Ramos

This experience report presents the last stage of the research entitled "Simulated teaching applied to the moral deliberation process in ethical problems experienced by nursing students and professionals", financed by the Coordination for the Improvement of Higher Education Personnel/CAPES and approved by the Ethics Committee for Research Involving Human Beings, via *Plataforma Brasil*, under CAAE no 41840915.1.0000.5361 and Consubstantiated Opinion no 990.530.

The moral deliberation method proposed by Diego Gracia[1-2] was the theoretical-methodological reference for the teaching-learning of moral deliberation in this simulated teaching experience carried out with nursing students from the 4th to 10th phases and nurses from the Ethics Committee of a University Hospital in Southern Brazil. One of the moral deliberation cases created by the researcher was used, based on the Guide presented in chapter 5. In the elaboration of the case each step of the Guide was followed, aiming to lead to reflection, discussion, and learning by the participants involved in the simulation. Figure 1 shows Diego Gracia's moral deliberation method (MDM) [1-2].

Figure 1 - Stages of the moral deliberation method. Source: Gracia[1]



In the application of the simulated teaching of the moral deliberation method, the following steps were included: (I) Planning; (II) Action; (III) Reflection /Debriefing.

I PLANNING

Construction and validation of clinical guidelines

The clinical guide was constructed by the author of the Project and reviewed by an expert in clinical simulation[V] who provided consulting in the development of the simulated teaching experiment.

CLINICAL GUIDE TO SIMULATION WITH ACTORS
THEME: MORAL DELIBARATION

Elaborated by: Dulcinéia Ghizoni Schneider

Revised by: Saionara Nunes de Oliveira[U]

General objective: Applying Diego Gracia's Moral Deliberation Method in a palliative care situation

General instructions

- Case title:

  PALLIATIVE CARE VS. DISPROPORTIONATE MEASURES

Type of simulation: Clinical Simulation with Simulated Participant (actors) and human patient simulator (mannequin)

- Time needed for the development of the simulation:
  - Scene 1: 15 minutes
  - Scene 2: 50 minutes
  - Scene 3: 10 minutes
  - Debriefing: 60 minutes
  - Total time needed to perform the activity: 2h45min

[U] Nurse. Master in Nursing. PhD student at the Graduate Program in Nursing at the Federal University of Santa Catarina (PEN / UFSC). Instructor in Simulation by the Universidad de Costa Rica - UCR. Member of the Brazilian Association of Simulation in Health - ABRASSIM and the Federación Latinoamericana de Simulación Clínica y Seguridad del Paciente - FLASIC

- Physical space needed: 2 simulated environments: Simulated Nursing Practice Laboratories and a Debriefing Room
- Number of simulated participants: 2 (women)
- Number of simulators: 1 (Human Patient Simulator) low fidelity
- Participants: five (students and/or nurses) per simulation. Three simulation sessions were conducted to contemplate the 14 participants

Information for participants

- The scenario takes place in an Intensive Care Unit (ICU)
- The first stage of the simulation takes place at the patient's bedside (Simulated Practice Laboratory) with the daughter, the wife, and the Nurse. The names John (patient), Ana (wife) and Marina (daughter) are all fictitious.
- The second stage takes place in the Support Room of the Simulated Practice Laboratory, where the participants, representing the multidisciplinary healthcare team, will be seated around a table and apply the method of moral deliberation
- In the third stage, the nurse and other members of the multidisciplinary team return to the ICU setting and talk to the daughter and the mother about the most prudent decision suggested by the group that applied the method of moral deliberation
- In the fourth stage, the Debriefing will take place in the Room destined for this activity
- Finally, Almeida et al's Scale of Student Satisfaction and Self-Confidence in Learning will be applied13 and the participants will also make a descriptive qualitative evaluation about the simulated teaching and the method of moral deliberation

Briefing

You are a Nurse in the Intensive Care Unit of a General Hospital and received a patient referred from the Emergency Department with the following clinical history

"John, 64 years old, male, is received in the Intensive Care Unit of a General Hospital with a diagnosis of lung cancer with metastases in the brain and bones. His

wife reports that he was under treatment with chemotherapy, has already finished the last cycle, but has been presenting generalized pain and, since yesterday, he is confused and has difficulty breathing. He is diabetic and has been presenting hypoglycemia."

You have been informed that the wife demands that the patient be maintained in the ICU, with the institution of invasive measures, contrary to the medical indication for Palliative Care. You need to talk to the family, expanding the information needed to apply, together with the healthcare team, the method of moral deliberation, presenting a proposal to the wife and daughter at the end of the discussion.

Medical record data

On physical exam, the patient is groggy, with a low level of consciousness, respiratory rate of 10 mrm, BP 98x64 mmHg, SatO2 89%, T.35,8oC, HR 104 bpm, dehydrated, no diuresis since yesterday, HGT 39mg/dL. The doctor prescribed analgesia, hypertonic glucose, O2 catheter at 3L/min and hydration. Mr. John has a weak peripheral venous network and the nurse punctured an external jugular vein.

Information to the actors (simulated participants)

Clinical case

Patient's history:

John, 64 years old, male, is received in the Intensive Care Unit of a General Hospital with a diagnosis of lung cancer with metastases in the brain and bones. His wife reports that he was under treatment with chemotherapy, has already finished the last cycle, but has been presenting generalized pain and, since yesterday, he is confused and has difficulty breathing. He is diabetic and has been presenting hypoglycemia.

The daughter who accompanies her mother reports to the Nurse that the medical team of the Specialized Oncology Hospital, where her father underwent treatment with chemotherapy and other treatments, explained that her father is in the terminal phase of the disease and indicated inclusion in palliative care protocol. However, her mother is resistant to the institution of this care because she believes that her husband can still recover from the disease and, because of this, she decided to bring him to a General Hospital.

The wife asks the doctor to keep her husband in the Intensive Care Unit and demands that all invasive life-sustaining measures (such as orotracheal intubation; deep venous access; vasoactive drugs; hemodialysis) be performed.

At this point the daughter contests her mother's request, saying that invasive measures will only prolong her father's suffering, since the medical team at the Oncology Hospital has explained that all the treatment currently available in medicine has already been carried out and that her father has not responded positively. However, the wife is emphatic and threatens to sue the health team if her request is not met and her husband dies.

The daughter reminds her mother that her father always commented that he did not want to be "suffering in a bed and that when death came, they should let him rest in peace. The mother recognizes that her husband talked about not wanting the prolongation of suffering in case of terminal illness, but says that she will not abandon him and that she is willing to do whatever is necessary for her husband to continue living, because he still has a way to heal.

Mr. João's family consists of his wife and his only unmarried daughter, 36 years old.

Expected behaviour:

Patient:

- Sleepy

Wife (Ana)

- Mentions being very anxious and afraid that her husband will pass away
- Asks the doctor and nurse that her husband be kept in the ICU and that the invasive measures necessary to maintain life be instituted
- Rudely insists that she is demanding that her husband have all the invasive care necessary to continue living
- Emphasizes that if their demand is not met, the team will be sued
- Shows impatience and aggressiveness when talking to the nurse and doctor

Daughter (Marina)

- Points out concern about his mother's decision, as he disagrees with her

- Wishes to take father home so he can receive palliative care at home, however, is not sure what palliative care is and whether the family would be able to afford to maintain this structure at home
- Opposes invasive measures that will prolong the suffering of her father who is terminally ill with metastatic cancer
- Demonstrates intense suffering with the situation, because he loves his father, does not want his death, but also, does not want to see him suffer knowing that he will not be cured and that his suffering will only be prolonged
- Discusses the situation of the mother who will also suffer because if the treatment is prolonged, the mother will be hopeful and may suffer even more with the outcome of death...or not...she may think that this way all the care has been done...
- The daughter also recalls that her father was always against the institution of disproportionate measures that would prolong her suffering if she was in a life situation with a reserved prognosis.

Debriefing stage

In this stage the participants will watch the footage of the entire simulation and will do a self-evaluation of their performance in the scenario. The evaluation will be quantitative and qualitative.

In the quantitative step, the Scale of Student Satisfaction and Self-confidence in Learning translated and validated in Brazil by Almeida et al,[13] whose use in this study was authorized by one of the authors (Rodrigo Guimarães dos Santos Almeida) via e-mail.

The scale is composed of 13 items of 5-point Likert type (ranging from 1= strongly disagree with the statement to 5 = strongly agree with the statement) divided into two dimensions: Satisfaction with current learning with five items; and Self-confidence in learning with eight items.

In the qualitative stage, the participants will evaluate all phases of the simulated teaching, from the instrumentalization of the moral deliberation method to the end of the simulation. All stages of the simulation will be filmed (with due authorization

from the participants) and during the Debriefing the participants will watch the footage to identify the strengths and weaknesses of the simulation.

Selection and training of mock participants [V]

The two participants selected to play the role of the patient's wife and daughter have experience with simulated teaching in the field of Nursing and have acted as Simulated Patients in various health disciplines and events.

The scenario test took place the day before the simulation and was conducted by the researcher who could make adjustments to the way the two characters acted and to the simulated clinical environment in order to strengthen the realism of the scene.

Organization and preparation of the stage set

The scenario included an Intensive Care Unit (ICU) room; a room attached to the ICU; and a meeting room.

The first scene takes place at the bedside of the ICU and attached room; the second scene is in the meeting room with the multidisciplinary health team (research participants); the third scene is again in the room attached to the ICU that represents a reserved space to talk to the family.

Invitation to participants (students and nurses)

The researcher announced the Project in the classrooms of the 4th to 10th phases of the Undergraduate Nursing Course of the local University where the Project was developed, inviting all students interested in participating. Fifteen students made themselves available; however, only ten actually participated in the stages of instrumentation and simulation.

Members of the Nursing Ethics Committee of the University Hospital where the study was conducted were also invited. The Commission is composed of nine members, being four nurses, three technicians and two nursing assistants. Of these, six participated

[V] El término Participante Simulado se refiere a cualquier persona, profesional o aficionado, que desempeña el papel de paciente, familiar, profesional de la salud u otros, con fines de educación para la salud. Este término fue adoptado recientemente por la Asociación de Educadores de Pacientes Estandarizados (ASPE).
Fuente: Lewis Karen L., et al. The Association of Standardized Patient Educators (ASPE) Standards of Best Practice (SOBP). Advances in Simulation. 2017; 2(1):1-10.

in the moral deliberation method instrumentalization stage and four nurses in the simulation stage.

Some of the members of this Commission had already participated in the first stage of this Project when questionnaires were applied to survey the most frequent ethical problems in nursing practice and also the workshops that are held with the nursing staff of the Hospital in an Extension Project coordinated by the researcher, created from the needs identified in the results of the first stage of this research Project entitled "Simulated teaching applied to the process of moral deliberation in ethical problems experienced by students and nursing professionals".

Instrumentation of the participants on the method of moral deliberation

The researcher gathered the participating students in three meetings and conducted workshops with the objective of teaching Diego Gracia's method of moral deliberation. Before starting the workshops, the researcher presented in detail the research objectives and method, and applied the Free and Informed Consent Term (FICT) to each of the participants.

The workshops were organized as follows:

a) The researcher presented Diego Gracia's method of moral deliberation in a dialogical exposition[1-2] and used texts by authors who apply the method, especially the author Elma Zoboli[12]. The reading and discussion of the texts was done by everyone together, with clarification of the concepts and each step of the moral deliberation method.

b) In the second workshop the researcher presented one of the cases of moral deliberation, built in the Project from the Guide presented in chapter 5 of this book, and applied with the group of students the method of moral deliberation.

c) In the third one, she reviewed the whole method and discussed the existing doubts and made a qualitative evaluation of the workshop, moment in which all participants exposed their learning, being very well evaluated by all.

The same workshop structure was applied with six members of the Nursing Ethics Commission of the University Hospital and had a positive qualitative evaluation.

It is worth mentioning that all participants, students and members of the Ethics Committee, were unaware of the moral deliberation method. They had never heard about moral deliberation and evaluated positively its application.

Other literature on moral deliberation by Diego Gracia and ethical discussions on limitation of therapeutic effort, the decision not to resuscitate, the initiation and termination of invasive life support measures, the request by family members to apply support measures perceived as disproportionate or futile; as well as the Professional Code of Ethics were made available, aiming at instrumentalizing the simulated teaching.

II ACTION

Case simulation: **PALLIATIVE CARE VS. DISPROPORTIONATE MEASURES**

The simulation occurred in three moments that we call scenes. Each scene represents a real context that requires clinical reasoning, decision-making and attitude from the participant(s). Some scenes represented the context of an Intensive Care Unit (ICU) and another, that of a multi-professional team meeting to apply the method of moral deliberation.

Importantly, the simulation, despite having "scenes," is not theater, but realistic acting in a simulated environment that fosters learning prior to experience with real patients in a hospital or other care setting. Only the simulated participants play a role. The students and nurses will act out a realistic scenario, without prior training, applying the knowledge gained from the moral deliberation method.

Scene 1: in the ICU

The nurse is evaluating the patient, Mr. João, and is visited by his wife, Mrs. Ana, and his daughter, Marina.

He introduces himself to the two and explains the patient's clinical condition and the measures taken so far by the healthcare team. The wife begins to alter her voice and demand that invasive measures be instituted for the patient to maintain his life.

The daughter tells her mother that instead of staying in the ICU, her father should go home with palliative care, as directed by the Oncology Hospital, since he has terminal lung cancer with brain and bone metastases.

The nurse explains that the healthcare team is attending to the patient's needs and asks the wife and daughter to go to the room next to the ICU to talk more calmly.

Scene 1 - Continuations in the ICU annex room

The patient's wife argues with the nurse demanding that the healthcare team perform all invasive procedures and mentions that if this is not done, she will sue the hospital as she is already doing with the other specialized oncology institution.

The nurse explains that Mr. John is receiving all the care he needs and that the doctor has prescribed analgesia, hydration, oxygen, hypertonic glucose and that they are following the evolution of his clinical picture.

At this point, again the wife makes threats to the health care team and the daughter intervenes saying that her father will suffer if he remains in the ICU with all the invasive measures that her mother is requesting be implemented. The daughter reports that her father always expressed that if one day he was terminally ill, he would not want his suffering to be prolonged. He wanted to have a dignified death and with his family. Therefore, the daughter requests that her father be discharged home from the ICU to be cared for with loving care. At this moment, the mother contests the daughter and says that, even though her husband has expressed that he wouldn't like to "stay suffering in a bed" she doesn't accept his death and wants him to remain in the ICU because he has a chance of cure.

The nurse asks the daughter if there is enough structure at home to maintain palliative care for Mr. João, and she replies that she doesn't know very well what palliative care is, but that she doesn't want to see her father's suffering prolonged.

The Nurse asks the two women to excuse her and says that she needs to talk to the health team about Mr. João's situation.

Scene 2 - Meeting Room - Application of the Moral Deliberation method by the research participants representing the multidisciplinary healthcare team

The group of participants (three nurses and two students) applies Diego Gracia's method of moral deliberation.

Below is the experience built by one of the groups that applied the method.

Deliberation on the facts

Clinical case presentation

The nurse who is coordinating the moral deliberation session presents the case:

Mr. João, admitted to the ICU, diagnosed with end-stage lung cancer with brain and bone metastases; he has finished the last cycle of chemotherapy treatment and there is no further medical indication of other types of treatment for the cancer, in view of the reserved prognosis. Palliative care was indicated at the Hospital Especializado em Oncologia. He presents with generalized pain, has been drowsy and groggy for two

days, and has periods of mental confusion. He has diabetes mellitus and is presenting hypoglycemia.

On physical examination, the patient is groggy, with a low level of consciousness, respiratory rate of 10 mrm, BP 98x64 mmHg, O2 sat 89%, T.35.8oC, HR 104 bpm, dehydrated, without diuresis since yesterday, HGT 39mg/dL. The doctor prescribed analgesia, hydration, O2 catheter at 3L/min and hypertonic glucose if necessary. Mr. John has a weakened peripheral venous network and the nurse punctured an external jugular vein.

Mr. João's family consists of his wife and 36 year old unmarried daughter who lives with her parents. The wife did not accept the indication of palliative care by the medical team of the Specialized Oncology Hospital and brought him to this General Hospital so that the patient could be admitted to the ICU and that invasive measures such as orotracheal intubation; deep venous access; vasoactive drugs; hemodialysis could be instituted. Patient has peripheral venous fragility in upper limbs and is with access in external jugular. The wife is very upset and demands invasive measures and to keep her husband in the ICU, otherwise she will sue the health team. The daughter understands the situation and accepts palliative care, but wants to take her father home, however, she does not have the necessary support to maintain palliative care at home.

Clarification of the facts of the case

One of the members of the multidisciplinary team (represented by the research participants) asked if Mr. João had any documents expressing his will in the case of terminal illness. The nurse who was presenting the case clarified that the daughter informed him that her father always said that if one day he was terminally ill, he would not want his suffering to be prolonged. He wanted to have a dignified death with his family, but the daughter has no written document.

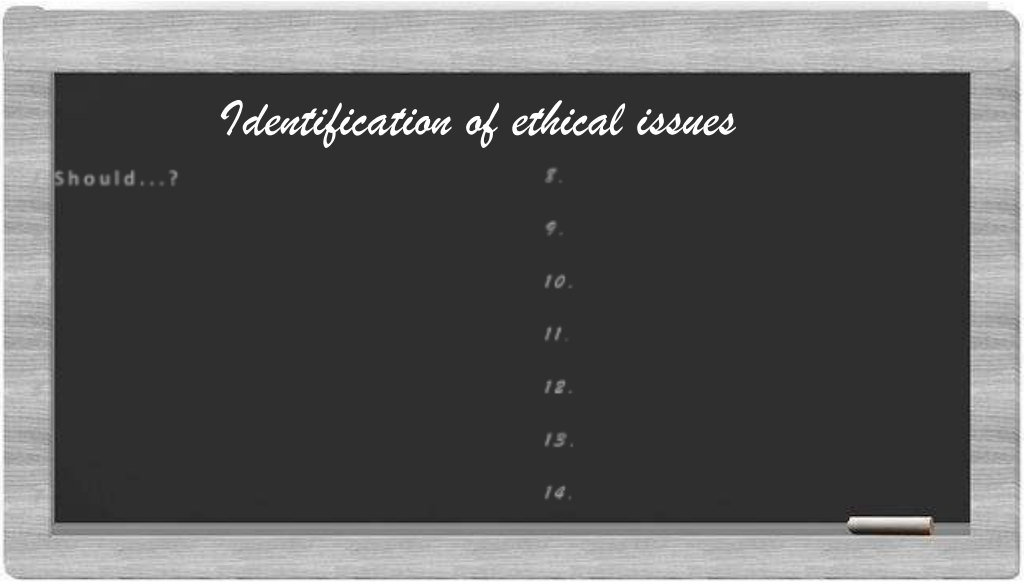
Other participants questioned whether the daughter asked for any guidance from the team, and the nurse coordinator of the deliberation session reported that the daughter asked the health team to talk to her mother, explaining the situation better because she does not want her father to be subjected to intense suffering if it will not reverse his critical condition.

The nurse also reported that the mother and daughter are in a conflict of decision about treatment: the daughter wants to take her father home and adopt

palliative care, but does not have the necessary support to do so. She wants to respect her father's wish not to prolong life by instituting extraordinary measures. The wife does not accept the implementation of palliative care. Considers it negligent of the health care team to plan palliative care. She is in denial about her husband's dying process.

Deliberation on values

Identification of ethical issues



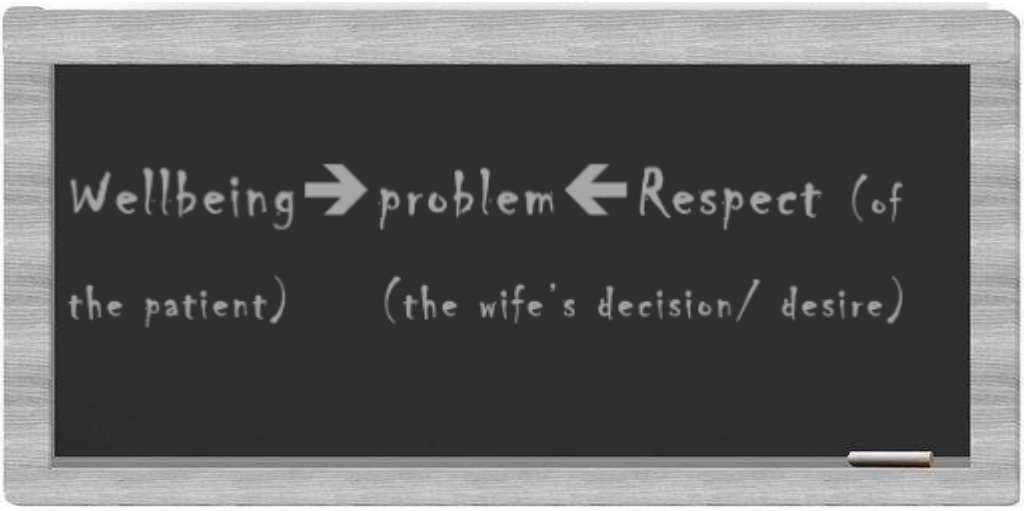
- Should a family member's wishes be respected when they seem to disregard the patient's previously expressed wishes?
- Should one respect the daughter's suggestion to implement home-based palliative care, considering that she doesn't really understand the complexity of this care and doesn't know if they would be able to afford it?
- Should any decisions be made before the relatives are fully informed about the consequences of the measures they are requesting?
- Should the prolongation of life be prioritized over the quality of life?
- Should one implement invasive and unnecessary measures when the patient is terminally ill?
- Should a patient be kept in the ICU without clinical indication?
- Would it be reasonable to indicate palliative care but keep the patient in the ICU?

- Is it fair to keep a patient in the ICU terminally ill when ICU beds are scarce and lacking for other recoverable patients?
- Should a patient's wishes be respected even when not documented?
- Should one grant a request for fear of prosecution?

Election of the ethical problem to be deliberated

Faced with the clinical indication for palliative care and the wife's request to institute invasive measures, what should I do?

Identification of conflicting values



Well-being (of the patient) X Respect (to the wife's decision/desire)

Deliberation on duties

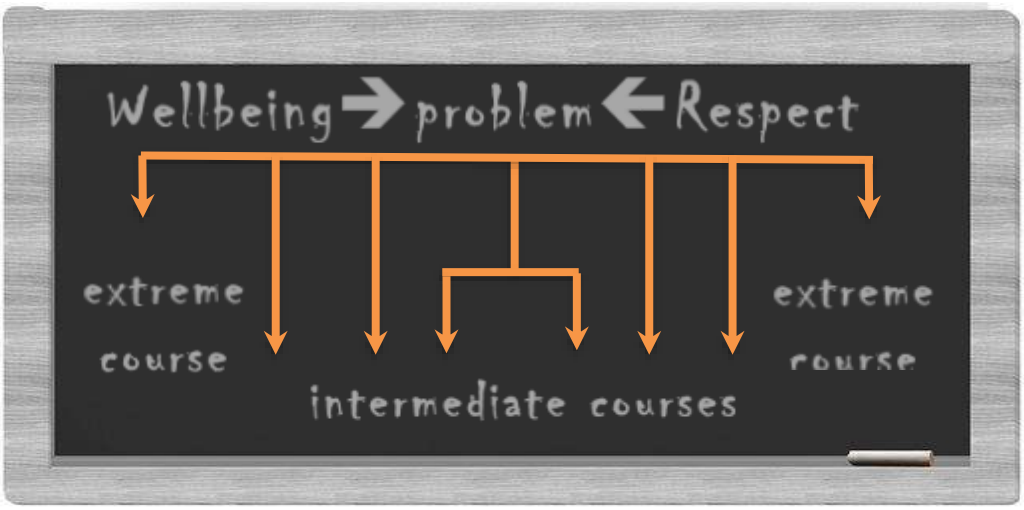
Identification of possible courses of action

Identification of extreme courses of action

a) Respect the wife's wishes and keep the patient in the ICU and institute invasive measures, maintaining life at any cost.

b) Respect the daughter's wishes and discharge her from the hospital so that palliative care can be performed at the patient's home.

Identification of intermediate courses of action



A. Start a multi-professional approach with the family, aiming to give support to the wife about the meaning of living with quality of life, re-signifying the health-disease, life-death process
B. Offer psychological support to wife and daughter
C. Explain to the family what palliative care means and the proposed care for Mr. João
D. Explain the disproportionate risks and discomfort of invasive procedures by taking futile measures
E. Keeping the patient hospitalized in a medical clinic unit with comfort measures
F. Extend visiting hours and allow the family to stay with the patient
G. Establish palliative care protocol in the hospital

Identifying the optimal course of action

a) Offer psychological support to wife and daughter
b) The multidisciplinary team meets with the wife and daughter to address the issue of the process of living and dying with quality and to clarify the palliative care proposal
c) Transfer the patient to an inpatient unit with palliative care, extended visitation, and family permanence

Application of the consistency tests of the optimal course of action

a) Proof of legality: the decision is supported scientifically, since all available treatment indicated for the patient's disease was instituted without success, resulting in a reserved prognosis. The institution of palliative care in this case is based on the health professional codes of ethics.

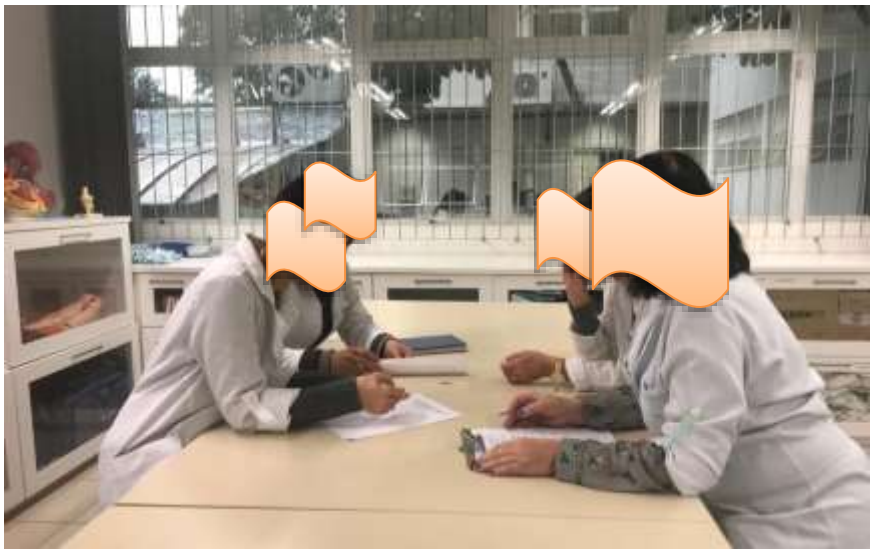
b) Publicity proof: the team's decision can be publicly defended because it is the most prudent one within the reality presented.

c) Proof of temporality: the team would choose this same course of action if they had more time to decide because the possibilities were sufficiently analyzed and there was no hurry in the decision making.

Final decision

Offer psychological support to the wife and daughter; meet the multidisciplinary team with the wife and daughter to address the issue of living and dying with quality and to clarify the palliative care proposal; transfer the patient to an inpatient unit with palliative care, extended visit and family permanence.

Scene 3 - ICU annex room - communication of the deliberation to family members



The multidisciplinary team met with the patient's wife and daughter and presented the suggested proposal in the moral deliberation session, clarifying all the doubts raised by the family. The daughter readily accepted the suggestion, but the wife asked for some time to think more about the proposal. The health team made the referral for psychological support and reinforced their availability to maintain contact and dialogue with the family throughout the patient's care.

III - REFLECTION/DEBRIEFING

During the Debriefing the participants made an initial evaluation of how they felt throughout the process and then watched the footage, pointing out the strengths and weaknesses of their performance in the simulation.

Qualitative evaluation performed by the entire group of participants on the application of the moral deliberation method and the context of the simulation

The evaluation of the whole process of the simulated teaching of moral deliberation was very positive from the planning to the realization of the simulated teaching. We present a qualitative and a quantitative evaluation.

Regarding the instrumentalization of the participants in Diego Gracia's[1-2] moral deliberation method (MDM) in the pre-simulation, the reports reflect the understanding of the method by the research participants based on the workshops conducted by the researcher, the availability of previous literature, and the application of the method together with the researcher in a case of moral deliberation. The participants felt secure in applying the method.

When the simulated teaching was evaluated, the participants were unanimous in stating that the simulation provides such a realistic environment that in the end it

compares what one would do in theory (idealization) and what one actually does (simulation). The participants felt safe to act upon the situation presented.

The number of participants per simulation group favored the involvement of all. This approach of theory to practice in a theme that is little developed in undergraduate nursing (approach to ethical problems of care) provided the participants with a successful experience, a collective discussion with respect, listening and being listened to by colleagues, in short showing that all professionals involved in the care process are important in their participation.

Simulated teaching is a technique that stimulates the development of reflective thinking and action, enabling the future professional to experience situations that will be faced in professional practice. In the evaluations, the participants emphasized the learning opportunity provided by the research, suggesting the continuity of the project so that other students and nurses can be contemplated, considering that they felt privileged to have participated in it.

In the evaluation of the application of Diego Gracia's moral deliberation method, it was pointed out that the previous instrumentalization was a positive aspect in a subject that they consider very subjective, ethics. The MDM organizes the thinking, empowers the team for decision making, and prevents ethical problems from becoming dilemmas that result in polarized decision making, that is, in two mutually exclusive possibilities. One of the participants even said that this method can help in the analysis of difficult decisions in personal life.

It was also reported that the method, the script, and the team made all the difference. They felt safe to discuss the simulated case and pointed out the relevance of team discussion, knowing how to listen and welcome other points of view, considering that all participants are important and can contribute with their knowledge.

Quantitative evaluation: application of the Scale[13] of student learning satisfaction and self-confidence

The Scale of Student Satisfaction and Self-Confidence with Learning, originally from the US, constructed by the National League for Nursing, validated for Portuguese by Almeida et al[13], was applied to the participants. The scale consists of a series of statements about the participant's personal attitudes about the guidance they

received during the simulation activity. Each of the 13 items, on a five-point Likert scale (ranging from 1-strongly disagree with the statement, 2-disagree with the statement, 3-indecisive; neither agree nor disagree with the statement, 4-agree with the statement, and 5-strongly agree with the statement), represents a statement about the participant's attitude regarding satisfaction with learning and self-confidence. The items are distributed into two dimensions: "Satisfaction with current learning" and "Self-confidence in learning". There are no right or wrong answers. The participant will probably agree with some statements and not agree with others.[13]

For the use of the Scale[13] in this context, considering the specificity of its application, three questions were adjusted to better refer to the theme addressed, that is, in items number 2 and 7 the term "medical-surgical curriculum" was replaced by "Moral Deliberation Method", and in item number 8, the already mentioned scenario "clinical environment" was complemented "with ethical conflicts".

The 14 participants responded to the Student Satisfaction and Self-Confidence in Learning Scale. The small number of participants did not allow us to make generalizations and quantitative associations in a representative way. In this sense, we chose to present the results descriptively in the evaluation of the simulation, as can be seen in Table 1.

Table 1 - Descriptive analysis of the Student Satisfaction and Self-Confidence in Learning Scale applied to the simulation participants. Florianópolis, SC - Brazil. 2019. (n=14)

Item description	1	2	3	4	5
	n(%)	n(%)	n(%)	n(%)	n(%)
Satisfaction with current learning					
1. The teaching methods used in this simulation were useful and effective	0	0	0	0	14(100)
2. Simulation provided me with a variety of teaching materials and activities to further my learning of the medical-surgical curriculum	0	0	0	0	14(100)
3. I liked the way my teacher taught through simulation	0	0	0	0	14(100)
4. The learning materials used in this simulation were motivating and helped me learn	0	0	0	0	14(100)
5. The way my teacher taught through simulation was appropriate for the way I learn	0	0	0	0	14(100)
Self-confidence in learning					
6. I am confident that I have mastered the content of the simulation activity that my teacher presented to me	0	0	1(7.1)	10(71.5)	3(21.4)

7. I am confident that this simulation included the content necessary for mastery of the medical-surgical curriculum content	0	0	0	1(7.1)	13(92.9)
8. I am confident that I am developing skills and gaining the necessary knowledge from this simulation to perform the procedures required in a clinical setting	0	0	0	5(35.7)	9(64.3)
9. My teacher used useful resources to teach simulation	0	0	0	1(7.1)	13(92.9)
10. It is my responsibility as the student to learn what I need to know through the simulation activity	0	0	0	2(14.3)	12(85.7)
11. I know how to get help when I don't understand the concepts covered in the simulation	0	0	1(7.1)	0	13(92.9)
12. I know how to use simulation activities to learn skills	0	0	1(7.1)	6(42.9)	7(50)
13. It is the teacher's responsibility to tell me what I need to learn in the theme developed in the simulation during the lesson	0	1(7.1)	6(42.9)	3(21.4)	4(28.6)

Source: Research Results. Scale by Almeida et al, 2015.
Key: 1 - Strongly disagree with the statement; 2 - Disagree with the statement; 3 - Undecided, neither agree nor disagree with the statement; 4 - Agree with the statement; and, 5 - Strongly agree with the statement.

In the dimension "Satisfaction with current learning" which refers to the five initial questions of the Scale, all participants 100% (n=14) strongly agreed with all statements, reflecting that all steps of the simulated teaching were useful and effective and that the simulation promoted learning by being motivating.

In the dimension "Self-confidence in learning", represented by questions 6 to 13, the answers were not unanimous as in the first dimension. In the analysis of these items, the response options "I agree with the statement" and "I strongly agree with the statement" were grouped together, because we believe they refer to the agreement with the items. Thus, questions 7 to 10 obtained 100% (n=14) agreement. In items 6, 11 and 12 there was 7.1% (n=1) of undecided in each one, and in item 13 there was 42.9% (n=6) of undecided and 7.1% (n=1) of disagreement.

In this way, only item number 13, which refers to the teacher's responsibility to say what the participant should learn during the simulation, generated greater differences in perception, where 50% of the participants agreed, and the other 50% were undecided or disagreed.

Finally, it was possible to verify through the measures of position and dispersion that in the dimension of satisfaction with learning the mean was 5.00, because 100% of the participants strongly agreed, without presenting variability. And in the dimension of self-confidence in learning, the mean was 4.56 (SD±0.30) indicating

high agreement. Thus, in general, it was identified, with the application of the scale, that in all items, grouping the agreement options, all or most participants agreed with the statements, indicating a positive evaluation of the simulation.

To minimize information bias, Cronbach's alpha was calculated as a measure of reliability, and a value of 0.60 was found for the instrument, which is acceptable in exploratory studies[14], as in this situation, but is limited by the small number of respondents and the zero variance of the first dimension.

Observation (by the researcher)

Data collection: with the authorization of all research participants and the application of the Free and Informed Consent Term (FICT) the entire simulated teaching process was filmed and photographed, and the debriefing stage was recorded. The speeches of the filming were transcribed, as well as the speech recordings of the debriefing.

Filming: the images recorded were filed by the researcher and will be deleted five years after the end of the research. They will not be used for purposes other than the research. It is worth mentioning that the participants authorized the publication of the images photographed for the purpose of disseminating the results of the research.

The researcher made a non-participant observation of Scene 1 performed in the ICU and attached room. Considering that in the simulation the protagonists are the learners, the researcher chose not to observe the participants applying the method of moral deliberation, in Scene 2, in order not to interfere in the dynamics of application

and because the scenes were being filmed and would later be watched in the stage of evaluation/ reflection/debriefing.

In the scenes observed, the "actresses" (simulated participants) developed their roles with great emotion and the students and nurses experienced the simulation acting appropriately, as expected from a professional in a similar context in professional practice. It is worth highlighting the adequate communication of the participants with the "actresses", the posture of welcoming the family, the concern not to argue with the "simulated patient", the qualified listening.

It is worth clarifying that the participating students and nurses were instructed on the application of the moral deliberation method and on the theme that would be approached, aiming at the appropriation of knowledge that would sustain the discussions, but there was no rehearsal of the scenes that would be experienced by them. The researcher rehearsed only with the actresses. The role of the nurse was developed by students from the 8th phase on, demonstrating maturity and experience with simulation, considering that in the Undergraduate Nursing Course of the University, where the study took place, activities with clinical simulation begin in the 3rd phase.

In the application of the moral deliberation method, scene 2, the participants questioned about the case presented, exposed their opinions, reflected on the care in a broad way, discussing the consequences of each course of action identified: the extremes, the intermediates and the optimum.

In scene 3, when the communication of the deliberation to the family members occurred, one can observe the argumentation capacity of the team, demonstrating security in what had been previously discussed, being evident the construction of knowledge provided by the discussion guided by the method of moral deliberation.

In the debriefing, each of the participants evaluated the whole process of the simulated teaching of moral deliberation, leading the researcher to conclude that it was a successful experience. Many participants thanked the learning opportunity and suggested that a discipline or a course be developed so that other students and nurses could be contemplated with this experience.

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FINAL CONSIDERATIONS

In finalizing this work, we thank all the participants of the study who engaged in its various stages for believing in the relevance of the theme. What mobilized the reflections developed by all was the commitment to ethical training in health and the challenge of developing strategies for the instrumentalization of the professional in facing the complexity of caring for human beings in their various dimensions.

We thank our colleagues, authors of the chapters presented here, who, with their expertise, dedication and belief in quality training in health, shared their knowledge to broaden the support of the knowledge developed in this research. Joint efforts contribute to the achievement of the objectives of training and continuing education in health.

We thank the Coordination for the Improvement of Higher Education Personnel/CAPES for funding this research, resulting from the Capes Thesis Award 2011 reverted into Research Project Funding. Research that has ethics as an object of study should be encouraged, aiming at the formation and action of health professionals in care that is not only technical, but ethical and humanized.

The information provided here can be applied within the context of teaching ethics under various methodologies that stimulate moral sensitivity and deliberate decision as the most prudent in the situation experienced in a given context, because the health professional needs to develop an empathic look and attitudes when caring for the human being.

The method of moral deliberation instrumentalizes health professionals in selecting the most prudent course of action in the various contexts of action, considering the clinical, psychosocial, spiritual, moral, and ethical aspects that involve the complexity of human living. Deliberation occurs through dialogue, respect for other points of view, and reflection on professional responsibilities and the consequences of actions. In this sense, educating through moral deliberation provides learning that can be used in day-to-day actions, in making difficult decisions, avoiding the dilemmatic options, which place the professional on the limits between two opposing options and subject to moral suffering.

The simulated teaching strategy was chosen among the various active methodologies available to concretize the teaching of ethics, since it offers the student the opportunity to act in a realistic situation, to be able to review his performance and to reflect on ethical behavior in situations that he will experience in professional practice. The opportunity to apply Diego Gracia's method of moral deliberation in a controlled realistic environment was considered unique by the participants in our reality and offered the possibility of systematizing the thought, listening to the opinions and points of view of colleagues, stimulated respect for divergent opinions, in short, it provided the ethical look both in the fictional situation presented and in living with colleagues from the multi-professional team, a characteristic of collective health work.

The Guide for the preparation of cases for the application of the moral deliberation method is another tool proposed in this research that offers the opportunity to direct and systematize fictitious cases that contain the necessary information for the application of the moral deliberation method in the development of ethical and moral competencies. This stage of construction and organization of simulated cases is also configured as a learning moment, providing an opportunity for reflection on the ethical problems experienced by health professionals in their practice.

Finally, we hope that this work contributes to the creation of teaching strategies that aim at the learning and development of ethical and moral competencies for the formation of a critical, reflective and active professional in the search for the best results in health care and quality of life for people.

Dulcinéia Ghizoni Schneider

Flávia Regina Souza Ramos