



Exploring the Impact of Mindfulness Training on Mindfulness and Ethical Decision Making in Pre-Licensure and Post Graduate Nurses

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Purpose:

The current healthcare environment is demanding of the attention of nurses. Studies have demonstrated that distracted, partially attentive people tend to engage in more unethical behaviors, which may negatively affect patient outcomes (Riskin, 2009). The complex, fast paced, high-stress, high-demand, technologically laden healthcare environment compromises providers' ability to be fully present in the moment, especially during patient interactions. This 'pulling away' of attention from the present moment creates a setting where the absence of awareness of one's present experience, also known as mindlessness (Ruedy & Schweitzer, 2011) exists. This state of mind contributes to unethical decision making, since awareness is a critical component of ethical decision making (Ruedy & Schweitzer, 2011). The current healthcare atmosphere is juxtaposed to the expectation that nurses provide focused patient-centered care within the framework of the culture of caring (Fox, et al., 1990) model at the heart of nursing. Building a more mindful nursing work force may assist in returning nurses and their attention to the bedside, thus enabling them to provide more mindful, ethical, patient centered care.

Mindfulness, rooted in Buddhist traditions, cultivates present-moment awareness through its practice (Riskin, 2009). Opposite of mindlessness, its goals include, fostering clearer thinking,

encouraging openheartedness, and maintaining awareness of the moment-by-moment experience (Ludwig & Kabat-Zinn, 2008). Mindfulness promotes compliance with applications of the “Golden Rule” also known as the ethic of reciprocity (do unto others as you would have others do unto you). It fosters a sense of interconnection, a deeper understanding of others, and develops a “wedge of awareness” that assists in noticing intentions (Flickstein, 2001; Riskin, 2009). Mindfulness helps one pause prior to acting in a way that would benefit themselves at the detriment of another (Riskin, 2009).

Mindfulness in healthcare is not novel; organized activities teaching mindfulness are already part of physician residency programs and have been incorporated into some medical school curriculums (Epstein, 1999; Ludwig & Kabat-Zinn, 2008). Mindfulness-based stress reduction (MBSR) has been used successfully to assist patients in alleviating suffering associated with physical, psychosomatic, and psychiatric disorders (Grossman, Niemann, Schmidt, & Walach, 2004). Presently, few schools of nursing or hospitals offer mindfulness training to nurses; however studies have demonstrated its effectiveness in improving levels of mindfulness in nursing students (Shields, 2011). It was hypothesized that a similar positive impact on mindfulness would be found, but further exploration of mindfulness training on mindfulness and ethical decision making in pre-licensure and post graduate nurses was sought.

Methods:

A time series two group (pre-licensure and post graduate nurses) design was used to explore mindfulness training on mindfulness and ethical decision-making. Following IRB approval, participants were recruited to participate in an 8-week mindfulness training program. A previously developed mindfulness program which was tailored to nursing was used to carry out training. The program was developed in collaboration with a mindfulness expert. The sessions, which were previously recorded expert led live audience sessions, were shown at each training session during the study. Each session was facilitated by trained faculty and consisted of guided practice, mindfulness education, and dialogues around participants’ feelings, thoughts, and sensations during practices. Sessions were held several times during the week in a classroom at the school. Efforts to accommodate the school and work schedules of the participants were made wherever possible. Sessions lasted 20 to 60 minutes.

During consent participants were informed that they would need to attend the sessions in order and miss no more than two facilitated sessions during the study. Participants who missed the live facilitated sessions were asked to watch the video for the missed sessions that were provided in the study’s online learning platform. The study’s online learning platform was created to facilitate communication with the study participants, to house session videos, to simplify completion of study assessments, and to provide study materials such as articles, weekly training schedules, and guided practice MP3 recordings.

Pre and post training assessments were completed. The Freiburg Mindfulness Inventory (FMI) (Walach, et al. 2006), and the Defining Issues Test of moral judgment version 2 (DIT-2) (Rest, 1975), were administered pre and post training. The FMI, used to measure mindfulness is a 30-item scale designed to measure aspects of mindfulness (Walach, et al. 2006). The DIT-2, used to measure ethical decision making is a vignette based measure of the beginnings of moral

understanding which are non-verbal and intuitive (Narvaes & Bock, 2010). Basic demographics were also collected pre training. A post training perceptions questionnaire developed by the PIs was also given to the participants following completion of the training. A \$75.00 gift card was given as compensation for participation in the study and was given to all participants who completed all required training sessions and also completed the FMI, DIT, pre-demographics, and post perceptions questionnaire.

Results:

Forty-five participants enrolled in the study (N= 34 pre-licensure, N= 11 post graduate). 27 participants completed the study (N=20 pre-licensure, 7 post graduate). Two participants' data were excluded from the FMI analysis because their pre-mindfulness scores were more than two standard deviations away from the mean. Analysis of Variance (ANOVA) and paired *t* tests were used to carry out the analysis.

Overall, there was a statistically significant improvement in the FMI scores $p = .003$. The pre-licensure group had a higher baseline FMI (mean = 36.79) as compared to the post graduate group (mean = 30.33, $p = .013$). Post training FMI scores were not found to be statistically significantly different ($p = .354$) when comparing the groups. While both groups improved their scores pre to post, the post training FMI score for the post graduate group (mean = 36.71) did not achieve the baseline scores of the pre-licensure group. The pre-licensure group did not show a statistically significant improvement in their FMI scores pre to post training ($p = .281$), however the post graduate group did ($p = .004$).

Statistically significant pre–post scores were found in two schemas of the DIT-2 (P [Post conventional] score, $p = .039$ and N2 [maintaining norms] score, $p = .032$). The post-conventional schema focuses on organizing a society by appealing to consensus-producing procedures, insisting on due process, and the safeguarding of minimal basic rights. Arguments presented in this schema include those appealing to moral ideals and / or theoretical frameworks. The maintaining norms schema focuses on the existing legal system, maintaining existing roles, and formal organizational structure. Arguments presented in this schema include those that appeal to maintaining social laws and norms (Bebeau and Thoma, 2003; Grometstein & Schilling, 2009).

Unlike the FMI findings, the post graduate group started out with higher baseline scores (P score mean = 46.57, N2 score mean = 37.62) as compared to the pre-licensure group (P score mean = 37.10, N2 score mean = 35.36).

Conclusion:

Mindfulness training improves mindfulness in both pre-licensure and post-graduate nurses, however the improvement is more profound in post-graduate nurses. While the improvement in mindfulness pre to post training was not surprising, it was interesting to note the differences found in the level of mindfulness in the post graduate nurse as compared to the pre-licensure group. Perhaps more remarkable is the inability to improve the mindfulness of the post graduate nurse to at least that of the baseline level of the pre-licensure nurse. This finding suggests that

there is a factor impacting this group making them less mindful to start out with and continue to have more difficulty with improving their mindfulness. Further investigation of mindfulness in post graduate nurses would need to be carried out to fully explore the impact that graduating and working in the field of nursing has on mindfulness. A more pointed understanding of how working as a nurse impacts mindfulness would allow more focused efforts aimed at improving it.

Mindfulness training likewise improves some aspects of ethical decision-making, especially those appealing to the maintenance of social laws, social norms, moral ideals, and theoretical frameworks. Improvements in mindfulness have been shown to improve stress levels, concentration, empathy, and through this study, ethical decision making. These findings, coupled with the improvements noted in mindfulness illuminate the need for introducing this type of training for nurses currently working in the field.

These findings are promising and further demonstrate the merits of a mindfulness practice, however aspects of mindfulness training would need to be addressed prior to launching a full scale attempt to incorporate this into a work life or some other quality improvement program. There was fairly large dropout rate among our participants, reasons included having difficulty in finding the time for training and practice with an already full work and / or school schedule. In addition, we had a small n, especially in the post graduate group. Despite having good effect sizes, even with the small n, further exploration of the concept would be prudent. Finally, we recruited from a single school of nursing, therefore our findings may not be generalizable to other organizations.

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