The Open Nursing Journal
DOI: 10.2174/0118744346652326102104532 8, 2026, 20, e187443466523
ISSN: 1874-4346

REVIEW ARTICLE **OPEN ACCESS**

Nurses as Ethical Guardians in the Intensive Care Unit: A Narrative Review of Bedside Ethics, Dignity, and Moral Responsibility

Faisal Alnahdi[1,*]

[1]*Cardiac Surgical Intensive Care Unit, King Faisal Specialist Hospital & Research Centre (KFSHRC), Riyadh, Saudi Arabia*

Abstract:

Introduction/Objective: ICU nurses provide continuous bedside care to patients who are unable to self-advocate, creating ethical risks that may be overlooked in routine critical care. This narrative review aimed to explore four ethical domains faced by bedside ICU nurses: sensory awareness in sedated and neuromuscularly paralyzed patients, cross-gender intimate care, dignity maintenance for brain-dead organ donor patients, and management of Do Not Attempt Resuscitation (DNAR) orders.

Methods: A structured literature search was conducted in February 2026 in PubMed/MEDLINE, CINAHL, and Scopus. English-language peer-reviewed studies, professional guidelines, and bioethics frameworks published from January 2010 to December 2025 were reviewed, with seminal earlier sources included through citation searching. Narrative thematic synthesis and gap analysis informed the review.

Results: Four interconnected ethical concerns were identified: the acoustic environment as an underrecognized ethical domain, privacy and modesty risks during cross-gender intimate care, potential reduction in care attentiveness after brain death declaration, and misinterpretation of DNAR orders as permission to reduce care intensity.

Discussion: Across these domains, patient incapacity transfers immediate moral responsibility to the bedside nurse. The findings support the concept of ICU nurses as ethical guardians who protect dignity, privacy, comfort, and care preferences when patients cannot speak for themselves.

Conclusion: Integrated nursing-specific ethics education, clearer bedside communication standards, improved documentation of dignity-related preferences, and institutional support for moral agency are needed to strengthen dignity-preserving ICU care.

Keywords: Nursing ethics, Intensive care unit, Patient dignity, Sedation awareness, DNAR, Organ donation, Moral distress.

© 2026 The Author(s). Published by Bentham Open.
This is an open access article distributed under the terms of the Creative Commons Attribution 4.0 International Public License (CC-BY 4.0), a copy of which is available at: https://creativecommons.org/licenses/by/4.0/legalcode. This license permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

*Address correspondence to this author at the Cardiac Surgical Intensive Care Unit, King Faisal Specialist Hospital & Research Centre (KFSHRC), Riyadh, Saudi Arabia; E-mail: inahdy@yahoo.com

Cite as: Alnahdi F. Nurses as Ethical Guardians in the Intensive Care Unit: A Narrative Review of Bedside Ethics, Dignity, and Moral Responsibility. Open Nurs J, 2026; 20: e187443466523.
http://dx.doi.org/10.2174/0118744346652326102104532 8

Received: June 16, 2026
Revised: September 03, 2026
Accepted: September 15, 2026
Published: November 13, 2026

Send Orders for Reprints to
reprints@benthamscience.net

1. INTRODUCTION

The Intensive Care Unit (ICU) is one of the most technically sophisticated and, therefore, ethically challenging areas of health care. Its central paradox is that the patients who most need the ongoing care are least able to advocate for it or to evaluate it: sedation, neuromuscular blockade, ventilation, and critical illness itself step-by-step remove the patients' capacity for self-advocacy [1]. This loss of voice does not cancel out but rather accentuates the moral dimension.

The development of critical care bioethics has unfolded over the past 20 years along two distinct pathways: the physician-centered pathway (withdrawal of treatment, DNAR, prognostication) and the abstract pathway of the 4 principles of Beauchamp and Childress [2]. Bedside nursing practice, which is the continuous, communicative, and tactile care that constitutes the vast majority of the patient's ethical experience, has received comparatively limited analysis [3, 4].

It is not a purely academic difference. Nurses are there when doctors are not: they speak for patients who are asleep and/or on a ventilator; they provide intimate care that patients cannot refuse or consent to; they interpret DNAR instructions on the spot; they continue to care for bodies that have been declared dead. They are the principal venues that shape the ethics of care in the ICU, but have been underrepresented in the nursing ethics literature [5, 6].

Some reviews focus on specific issues in this area: Selvaraj *et al*. [7] on the challenges that ICU nurses face in organ donation, Giles and Moule [8] on nurses' attitudes and experiences regarding DNAR decision-making, and broader reviews on moral distress [5, 6]. However, the cross-gender intimate care of incapacitated patients is an under-examined topic, especially when modesty and same-gender care preferences are culturally or religiously important. This review is unique in bringing together in one bedside-nursing framework these four domains: sedation awareness, cross-gender intimate care, organ donor dignity, and DNAR management.

The common feature of these domains is that the patient is unable to advocate for themselves and that the nurse is always responsible for upholding the dignity, privacy, comfort, and moral status of the patient. They are all due to a form of incapacity, either sedation, neuromuscular blockade, critical illness, or brain death, and in each case, it is the nurse who is the moral agent on behalf of an individual who is unable to act for himself.

1.1. Aim

The objectives of this narrative review are: 1) to identify and analyze four key areas of ethical challenge in bedside ICU nursing; 2) to show that, to the best of the author’s knowledge, these areas have not been integrated in the existing literature in a nursing-centered way; and 3) to propose evidence-based recommendations for nursing practice based on the concept of nurses as ethical guardians for incapacitated patients.

1.2. Research Questions

This narrative review was guided by the following research questions:

[1] What bedside ethical challenges are faced by ICU nurses when caring for sedated, paralyzed, unconscious, brain-dead, or DNAR-status patients?
[2] How do the four domains of sedation/paralysis awareness, cross-gender intimate care, organ donor dignity, and DNAR management relate to patient dignity and nursing moral agency?
[3] How can the concept of the nurse as an ethical guardian inform ICU nursing education, bedside practice, and institutional ethical support?

2. METHODS

2.1. Review Design

Structured searching of literature resources and gap analysis have been used to inform this narrative review. A narrative design was selected as the evidence in the field of ICU nursing ethics includes heterogeneous evidence, qualitative studies, guidelines, and bioethics frameworks, which are not appropriate for quantitative synthesis. Reporting quality was guided by SANRA principles for narrative review articles [9]. Formal quality appraisal tools such as GRADE or CASP were not applied because this was a narrative review; this limitation is acknowledged in the Limitations section.

2.2. Databases and Search Date

In February 2026, a structured search was performed in three databases: PubMed/MEDLINE, CINAHL, and Scopus. Hand searches of the reference lists of all retrieved eligible papers were conducted to identify additional sources.

2.3. Search Concepts and Strategy

Search strings combined the following core concepts using Boolean operators (AND, OR): Core concepts: (“intensive care unit” OR “critical care” OR “ICU”) AND (“nursing” OR “nurse”). Domain 1: Sedation/paralysis: AND (“sedation awareness” OR “neuromuscular blockade” OR “consciousness” OR “auditory awareness” OR “awareness under paralysis”). Domain 2: Intimate care: AND (“intimate care” OR “personal hygiene” OR “cross-gender care” OR “privacy” OR “patient dignity” OR “bodily dignity”). Domain 3: Organ donation: AND (“organ donation” OR “brain death” OR “donor care” OR “deceased donor”). Domain 4: DNAR: AND (“DNAR” OR “do not attempt resuscitation” OR “DNR” OR “end-of-life” OR “withholding resuscitation”). Cross-domain: AND (“ethics” OR “ethical challenges” OR “moral distress” OR “moral agency” OR “dignity”).

2.4. Inclusion and Exclusion Criteria

Sources included were peer-reviewed research, reviews, guidelines, or ethics frameworks published in English that dealt with ethical dimensions of adult ICU

nursing that relate to one or more target domains, primarily from January 2010 to December 2025. Citation searching was also performed, and seminal earlier work [10] was also included. Those sources that focused on only pediatric, neonatal, or non-ICU settings, physician/institutional-only perspectives, and abstract-only records were excluded.

2.5. Study Selection and Source Identification

Following the removal of duplicates, the first author scanned the titles and abstracts of the studies for eligibility, requesting full texts for potentially relevant studies. Thematic synthesis of the key sources directly related to bedside ethics in the ICU was performed from this pool. It is a narrative review; the exact number of sources is not given. The reference list has been inserted to reflect all the sources used.

2.6. Gap Analysis

A gap analysis was completed, whereby retrieved studies were compared to the four domains and three dimensions: (a) nursing *versus* physician perspective, (b) integrated *versus* single domain analysis, and (c) bedside *versus* institutional/policy focus. To our knowledge, no previous review combined all four domains from an exclusively bedside nursing perspective (Table **1**), thus making the present review needed.

2.7. Thematic Synthesis

The results were grouped into the four domain labels: evidence-based, ethical challenge for bedside nurses, documented issues of practice, and evidence-informed recommendations. The synthesis of the 'ethical guardian' framework was an iterative process, informed by the principles of autonomy, beneficence, non-maleficence, and justice [2], and nursing ethics theory.

3. RESULTS

Findings are reported narratively across the four ethical domains identified through the structured search and gap analysis. The gap analysis (Table **1**) revealed that, to our knowledge, no previous review had included these four aspects in a single bedside nursing framework.

3.1. Theme 1: The Acoustic Environment as Ethical Domain in Sedation and Paralysis Awareness

One of the most commonly held beliefs in intensive care medicine is that patients who are sedated or paralyzed will not be aware of their surroundings. There is no evidence to support this, and direct implications for bedside nursing behavior are sparse.

Hearing is one of the last senses to be affected by sedation and one of the first senses to regain function [10]. On the other hand, Jones *et al*. [11] discovered that ICU survivors had high rates of recollection of sounds and conversations from what they thought was unconscious time, and that negatively valenced auditory memory, especially overheard clinical conversations, was independently related to subsequent PTSD. Similarly, Granja *et al*. [19] reported that auditory memories were among the most common recollections from patients with post-ICU psychological morbidity, and Samuelson [12] reported that unpleasant sound memories, procedural distress, and verbal exchanges among staff resulted in long-term psychological sequelae in patients who had been intubated and ventilated.

Ethics are further complicated by the use of Neuromuscular Blocking Agents (NMBAs), like vecuronium, rocuronium, and atracurium, which are used to block motor responses but do not provide sedative or analgesic effects on their own [20, 21]. A patient receiving an NMBA can be completely awake, may be in pain and frightened, but cannot communicate. Puntillo *et al*. [22] reported the presence of considerable procedural pain and distress in critically ill patients, highlighting the importance of adequate analgesia and nurse sensitivity. While the odds of being awake during a paralyzing procedure are not easy to calculate, they are not to be ignored.

Table 1. Gap analysis: existing literature and the contribution of this review.

Domain	Focus of Existing Literature	Missing Nursing-Bedside Perspective	Contribution of this Review
Sedation/paralysis awareness	Sedation protocols; pain assessment tools; post-ICU psychological outcomes [11, 12].	Nurse vocal/communicative behavior as an ethical act; 'ethical acoustics' framework for education.	First integration of auditory awareness evidence into a nursing communicative ethics argument
Cross-gender intimate care	General dignity in care [13]; intimate care and clinician touch [14, 15]; patient preferences regarding nurse gender and opposite-gender care [16, 17].	Limited ICU-specific analysis of incapacitated patients who cannot express privacy, modesty, or same-gender care preferences during intimate nursing procedures.	Frames cross-gender intimate care of incapacitated ICU patients as an under-addressed bedside ethics issue requiring proactive documentation, privacy protection, same-gender care where feasible, and culturally / religiously sensitive nursing practice.
Organ donor dignity	Organ donation process challenges: nurse support [7, 18].	Day-to-day nursing care behaviors after brain death declaration: moral ambiguity about the nurse's role.	Focuses on bedside care quality as both ethically and clinically required; addresses nurse identity confusion.
DNAR management	Nurse attitudes and experiences regarding DNAR decision-making [8]; end-of-life discrepancies [3].	Differentiation of moral distress subtypes; cross-cultural DNAR communication in multicultural ICU settings.	Distinguishes three forms of DNAR-related moral distress requiring distinct responses; adds a cross-cultural dimension.

Abbreviations: ICU = intensive care unit; DNAR = Do Not Attempt Resuscitation.

What this review adds is that this evidence is couched as an ethical discussion, not just on assessment of sedation or scoring of pain, but overall acoustic and communicative environment of the ICU. Actionable, ethically concerning nursing behaviors identified are:

- Having conversations within hearing distance of the bedside related to diagnosis, prognosis, or personal information about the patient, even if the patient is apparently conscious.
- Use of language that is casual, depersonalizing, or task-oriented, in which the patient is reduced to a clinical object, which is documented in qualitative nursing studies to occur in high workload situations [4].
- Not calling the patient by name and describing what is about to happen is a simple behavior, shown to have positive effects on psychological patient experience and recall after an ICU stay [10, 11].
- Leading loud social discussions between staff over the patient's bed, which patients have said in retrospect were one of the most distressing aspects of their experience in the intensive care unit [12].

This review suggests a new concept, 'ethical acoustics' for nursing education: All speech in the potential auditory range of a patient is an ethical act, and the level of bedside communication should be matched to that required for a fully awake and competent patient.

3.2. Theme 2: Cross-Gender Intimate Care and the Suspended Right to Privacy

In health care, patients have the right to privacy, dignity, consent, and appropriate chaperoning during intimate care [23]. The patient's right to exercise this is suspended in the ICU by critical illness and altered consciousness, but the right itself remains intact; responsibility falls to the nursing team to uphold the right.

Intimate care can be felt as exposing, depersonalizing, or dignity-threatening experiences for patients who are in need of support from staff for hygiene, positioning, and care of the body [13, 24-26]. Clinician touch is also found to be sensitive, influenced by privacy, communication, consent, and patient preference [14], and poor management of exposure and touch can cause helplessness and disrespect [15], according to a qualitative systematic review. These are all very relevant to the role of the ICU nurse, as sedated or critically ill patients may not be able to ask for privacy, object to exposure, or express discomfort.

There has been limited research specifically addressing the cross-gender dimension in the ICU. Wider nursing evidence indicates that some patients prefer same-gender nurses for intimate procedures because of modesty, religion, or cultural beliefs [16, 17]. This concern is relevant in Saudi and Muslim contexts of critical care, where modesty, family involvement, privacy, and care that is sensitive to gender may shape nursing practice [27]. However, limited research has addressed the situation in which intimate care is provided in an ICU to a patient of a different gender who is incapacitated and cannot communicate, object, or express preferences, yet retains the right to dignity, privacy, and culturally sensitive care.

The literature recommends the following practices: active maintenance of privacy (full curtains, exclude unnecessary staff), verbal explanation of each step, even if the person is conscious, formal assessment and documentation of gender-related preferences, and handover communication of gender-related preferences [14, 15, 23]. If same-gender care is not immediately available, nurses should minimize exposure, explain the need for it, ensure a chaperone is present if appropriate, and restore privacy as soon as possible. These are not measures to remove the ethical risk, but show proactive safeguarding of dignity for those who cannot protect their own dignity.

3.3. Theme 3: The Brain-Dead Organ Donor and Sustaining Dignity After Legal Death

The legal and clinical determination of brain death does not remove the nurse's responsibility to provide dignified care to the donor's body and to support the family. The literature has reported on reduced care attentiveness after brain death declaration, due to an assumed premise that the patient no longer needs or experiences care [18]; although this is not always the case, it is a pattern that has been reported in a range of qualitative studies in different countries.

On a number of grounds, this pattern is an ethical issue. Physiologically, the efforts to maintain hemodynamic stability, temperature regulation, endocrine balance, and infection prevention are interlinked with organ viability; therefore, any loss of nursing care quality is ethically and clinically significant [28]. Family trust, bereavement, and willingness to proceed with the donation or recommend donation are all indirectly impacted by the quality of care observed by the donor's family.

Studies on organ donation in the intensive care units have shown that nurses may experience donation-related care as emotionally and ethically complex, specifically during the transition from curative treatment to donor management [7, 18, 29]. Family members' experiences of organ donation requests after brain death also show the importance of communication, trust, and observed care quality in the critical care setting [30]. The present review extends this literature by specifically examining day-to-day care behaviors (physical care quality, the communicative environment at the bedside, and language used in handover and documentation) instead of the donation process and support structures.

Simonsson *et al*. [18] reported qualitative findings of nurses, especially those inexperienced in organ donation, expressing uncertainty over whether they were 'caring for a living person or a dead one'. When not addressed by institutional culture or leadership, this moral ambiguity is a factor that reduces care quality and increases moral distress [7, 18]. In all the sources reviewed, the continued ethical responsibility for the body of the donor, clear

education for the nurse, and the emotional complexity of the role are identified as institutional ethical obligations.

3.4. Theme 4: DNAR Orders and the Limits and Obligations of Nursing Practice

Do Not Attempt Resuscitation (DNAR) orders rank high among the most ethically laden documents in the course of an ICU patient's care. Much of their management is delegated to nursing staff as the first responders to clinical deterioration. Nursing literature regarding DNAR orders is relatively advanced, but there are still important practice gaps. The most frequently reported issue in this area is that DNAR orders may be interpreted as indicating that care intensity can be reduced, even though DNAR should apply only to resuscitation and not to other aspects of nursing or medical care [8, 31-33]. The literature has raised concerns that DNAR decisions could be related to uncertainty, decreased intensity of care, or confusion regarding the continuing scope of responsibilities for nursing, specifically when communication and policy guidance are not clear [8, 33].

Ferrand *et al*. [3] also reported systematic differences between physicians' intent and nurses' interpretation of end-of-life directives in French ICUs. Al Farhan *et al*. [33] highlighted the importance of clarifying that resuscitation-limitation orders should not restrict other appropriate treatment options. Cook and Rocker [34] confirmed that the care required for dignity in dying in the ICU is active and ongoing nursing care, and that this should not be interpreted to be reduced by DNAR status.

This review builds on this existing analysis to highlight three specific concerns relating to nursing practice, which have been reported across multiple sources but have not been examined together: (1) the DNAR-to-reduced-care misinterpretation described above; (2) inadequate DNAR communication at handover, a patient safety concern documented in qualitative nursing research [8]; and (3) underutilization of ethics consultation resources when nurses experience moral distress in relation to DNAR decisions [5, 6].

In the context of DNAR and end-of-life care, moral distress can manifest in several ways, some of which overlap in the literature but need to be addressed institutionally [35-37]: Distress from perceived futility (performing resuscitation on patients whom nurses believe will not benefit); Distress from perceived abandonment (feeling that DNAR status has lessened the quality of care); and Distress from family or team pressure to contradict carefully considered decisions [5, 6]. It is identified that there is a significant gap in nursing education and institutional policy in differentiating these forms.

Another aspect that needs to be emphasized more is the link between DNAR orders, family communication, and cultural or religious beliefs regarding death, duty, and acceptable limits of treatment. In culturally diverse ICUs, nurses can feel interpersonally and ethically challenged if families believe that DNAR is a form of abandonment or that it conflicts with their personal values. The general palliative care literature emphasizes the significance of effective communication, family engagement, cultural sensitivity, and support from the healthcare system in handling these scenarios [38, 39]. Therefore, institutional practice priorities should be given to culturally sensitive communication with the family, clear handover of the scope of DNAR, and access to ethics consultation, instead of optional supports.

4. DISCUSSION

A common structural finding presented in this review is that the nurse's continuous moral focus at the bedside underlies the four ethical domains explored herein. This review therefore proposes the role of ICU nurses as ethical guardians at the bedside.

It is important to note that the term 'ethical guardian' is not intended as a legal guardian, but a conceptual and professional approach to nursing ethics; the concept of ethical guardianship is distinct and different in significant ways from the more popularly discussed concept of nursing advocacy. According to the International Council of Nurses [40] Code of Ethics, advocacy is when the nurse stands in for or represents a patient who may, for the time being, be unable to speak for themselves. Guardianship suggests a more active and more fundamental role, one of protecting the dignity, privacy, autonomy, and welfare of a patient when the patient is not able to do so, even for the short term. In the ICU, nurses are not merely surrogates for patients who may regain the ability to communicate; they are often the only moral actors protecting patients' rights from violation.

The framework is based on bioethical principles of Beauchamp and Childress [2]. Autonomy (respect for the patient's right to direct the care) does not disappear upon incapacitation; instead, it imposes a responsibility on those exercising authority on behalf of the patient to respect his or her values and preferences as though the patient had expressed them. Beneficence (doing what is in the best interests of the patient) and non-maleficence (doing no harm) mean that nurses need to be aware of potential harms that are part of seemingly normal practices: conversations overheard by patients, improperly managed intimate care episodes, reduced attention after brain death declaration, and misapplied DNAR orders. These standards must be uniformly applied, irrespective of whether the patient is conscious, has a poor prognosis, or lacks decision-making capacity. The ability and motivation to act on these principles, called moral agency, is what makes a competent nurse an ethical guardian [5]. The findings of this review are consistent with previous literature showing that ICU ethical challenges are often experienced by nurses at the level of daily bedside care rather than only through formal decision-making processes. Studies on sedation awareness and post-ICU recollections suggest that communication around apparently unconscious patients may have psychological and ethical consequences. Similarly, studies on dignity, intimate care, and gender-related care preferences show that bodily exposure and clinician touch can become

ethically significant when patients cannot express consent, refusal, or preferences. In organ donation and DNAR management, previous studies show that nurses may experience uncertainty, emotional conflict, or moral distress when the meaning of continued care is unclear. This review differs from previous single-domain studies by interpreting these issues as interconnected expressions of a single shared ethical problem: patient incapacity transfers immediate moral responsibility to the bedside nurse.

The gap analysis highlighted that the literature to date has partially addressed each of the four domains: organ donation [7], perceptions of DNAR [8], post-ICU sequelae [12], and broader dignity literature and intimate-care literature on privacy, touch, modesty, and gender-specific care preferences [13, 14, 16, 17]. To the best of our knowledge, no previous review has brought all four together in a single nursing-centered approach. The integration is the contribution and the fact that these areas are not separate issues, but manifestations of the same one: patient incapacity and the devolution of moral responsibility to the bedside nurse.

This integration has a direct practical impact. An ICU nurse with knowledge of DNAR ethics but not sedation awareness ethics may, nonetheless, say the wrong thing at the bedside of a paralyzed patient. Even if a nurse is familiar with the dignity of intimate care but not donor care ethics, they may be more likely to lower the standard of physical care after the brain death declaration. The evidence, together, indicates the need for integrated ethical education, that is, education that explicitly relates all four of these domains within the framework of nursing guardianship.

Limitations of this review should be acknowledged. It is a narrative review and is potentially subject to selection bias; the sources were selected by the author as being relevant and may not be fully representative of the available literature. There is also a differential evidence base across the four domains, with the literature on DNAR management and organ donation stronger for ICUs as a whole, and literature on intimate care and dignity and gender preferences less developed, with some literature coming from more general hospital literature. Much of the literature is from European, North American, and other high-income or urban health care environments and therefore may not be applicable to settings with different staffing ratios, cultural norms, resource levels, or legal frameworks. Another restriction is that the ethics of practices in question are often recorded in qualitative studies and are not necessarily of a generalizable nature, especially in connection with the acoustic environment, intimate care exposure, and care attentiveness after brain death. Lastly, the 'ethical guardian' model presented here is conceptually-based and needs to be tested as an educational and practice model.

Future research should focus on: the development and evaluation of nursing ethics teaching programs in the intensive care unit that are integrated within multiple domains; prospective qualitative and observational studies to assess how often and in what context the ethical concerns described in each domain occurred; cross-cultural comparative studies; and the empirical evaluation of the ethical guardian as a model for teaching. The practical nursing recommendations derived from the four ethical domains are summarized in Table **2**.

Table 2. Summary of nursing practice recommendations by ethical domain.

Ethical Domain	Main Ethical Risk	Nursing Responsibility	Practical Bedside Recommendation	Education/policy Implication
Sedation/paralysis awareness	Patient hears conversations while unable to respond; trauma from overheard distressing content.	Maintain communicative conduct at all times as if the patient is fully awake.	Address the patient by name before all procedures; avoid casual or depersonalizing speech at the bedside.	Incorporate 'ethical acoustics' into ICU nurse orientation; include NMBA awareness in mandatory sedation training.
Cross-gender intimate care	Patient unable to express privacy, modesty, or same-gender care preferences; risk of exposure, embarrassment, and dignity violation.	Proactively protect privacy and honor documented care preferences.	Document gender-related care preferences where possible; maintain full privacy during all intimate care; explain each step; use a chaperone or same-gender staff when feasible.	Include cross-gender intimate care ethics in ICU orientation; develop culturally and religiously sensitive admission assessment and handover prompts.
Organ donor dignity	Reported reduction in care quality following brain death; family observation of care; nurse moral ambiguity.	Maintain full physical and communicative care standards regardless of brain death status.	Continue hygiene, positioning, temperature management, and respectful communication at the bedside.	Mandatory brain death ethics education; access to peer support and debrief after donor cases.
DNAR management	Misinterpretation of DNAR as reduced-care permission; inadequate handover; unexpressed moral distress.	Apply DNAR exclusively to resuscitation decisions; maintain full care in all other domains.	Explicitly communicate DNAR scope at every handover; seek ethics consultation when morally distressed.	Differentiated moral distress education; standardized DNAR handover protocols; formal ethics consultation access.

Abbreviations: DNAR = Do Not Attempt Resuscitation; NMBA = Neuromuscular Blocking Agent.

CONCLUSION

ICU nurses are not silent receptors of decisions made by others regarding ethical issues. They are active moral agents who, in the day-to-day practice of bedside care, can make the difference between the incapacitated patient's rights, dignity, and welfare being respected or undermined. The four domains that were explored in this review, namely, the acoustic environment for sedated and paralyzed patients, cross-gender intimate care, brain-dead organ donors, and DNAR order management, are among the most clinically prevalent and ethically consequential areas of nursing practice in the ICU.

Mistakes in these areas are not necessarily ones of personal intentions. They are educational failures, cultural failures of the institutions, and collective moral failures of critical care environments. This occurs through ongoing, comprehensive, nursing-specific ethics education; institutional structures that promote moral agency and limit moral distress; and leadership that exemplifies moral stewardship as a professional norm.

The silent patient is not ethically invisible. Their silence is the condition for the nurse's ethical guardianship, which is therefore possible and necessary.

AUTHOR'S CONTRIBUTIONS

The author confirms sole responsibility for the following: study conception and design, data collection, analysis and interpretation of results, and manuscript preparation.

LIST OF ABBREVIATIONS

CINAHL	=	Cumulative Index to Nursing and Allied Health Literature
CPR	=	Cardiopulmonary Resuscitation
DNAR	=	Do Not Attempt Resuscitation
DNR	=	Do Not Resuscitate
ICU	=	Intensive Care Unit
MEDLINE	=	Medical Literature Analysis and Retrieval System Online
NMBA	=	Neuromuscular Blocking Agent
PTSD	=	Post-traumatic Stress Disorder
SANRA	=	Scale for the Assessment of Narrative Review Articles

CONSENT FOR PUBLICATION

Not applicable.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

ACKNOWLEDGEMENTS

The author recognizes the role of ICU nursing practitioners in everyday ethical practice in complex clinical environments as a motivator for this review.

REFERENCES

[1] Papathanassoglou EDE. Psychological support and outcomes for ICU patients. Nurs Crit Care 2010; 15(3): 118-28. http://dx.doi.org/10.1111/j.1478-5153.2009.00383.x PMID: 20500650

[2] Beauchamp TL, Childress JF. Principles of Biomedical Ethics. (8th ed.), New York: Oxford University Press 2019.

[3] Ferrand E, Lemaire F, Regnier B, *et al*. Discrepancies between perceptions by physicians and nursing staff of intensive care unit end-of-life decisions. Am J Respir Crit Care Med 2003; 167(10): 1310-5. http://dx.doi.org/10.1164/rccm.200207-752OC PMID: 12738597

[4] Ramathuba DU, Ndou H. Ethical conflicts experienced by intensive care unit health professionals in a regional hospital, Limpopo province, South Africa. Health SA 2020; 25(0): 1183. http://dx.doi.org/10.4102/hsag.v25i0.1183 PMID: 32391174

[5] Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics 2009; 20(4): 330-42. http://dx.doi.org/10.1086/JCE200920406 PMID: 20120853

[6] Fumis RRL, Junqueira Amarante GA, de Fátima Nascimento A, Vieira Junior JM. Moral distress and its contribution to the development of burnout syndrome among critical care providers. Ann Intensive Care 2017; 7(1): 71. http://dx.doi.org/10.1186/s13613-017-0293-2 PMID: 28639161

[7] Selvaraj N, Baillie J, Jones J, Edwards D. Challenges and support strategies for intensive care unit nurses in the organ donation process: A scoping review. J Adv Nurs 2026; 82(8): 7717-34. http://dx.doi.org/10.1111/jan.70384 PMID: 41230715

[8] Giles H, Moule P. 'Do not attempt resuscitation' decision-making: A study exploring the attitudes and experiences of nurses. Nurs Crit Care 2004; 9(3): 115-22. http://dx.doi.org/10.1111/j.1362-1017.2004.00065.x PMID: 15152753

[9] Baethge C, Goldbeck-Wood S, Mertens S. SANRA—A scale for the quality assessment of narrative review articles. Res Integr Peer Rev 2019; 4(1): 5. http://dx.doi.org/10.1186/s41073-019-0064-8 PMID: 30962953

[10] Lawrence M. The unconscious experience. Am J Crit Care 1995; 4(3): 227-32. http://dx.doi.org/10.4037/ajcc1995.4.3.227 PMID: 7787917

[11] Jones C, Bäckman C, Capuzzo M, Flaatten H, Rylander C, Griffiths RD. Precipitants of post-traumatic stress disorder following intensive care: A hypothesis generating study of diversity in care. Intensive Care Med 2007; 33(6): 978-85. http://dx.doi.org/10.1007/s00134-007-0600-8 PMID: 17384929

[12] Samuelson KAM. Unpleasant and pleasant memories of intensive care in adult mechanically ventilated patients—Findings from 250 interviews. Intensive Crit Care Nurs 2011; 27(2): 76-84. http://dx.doi.org/10.1016/j.iccn.2011.01.003 PMID: 21371888

[13] Stephen Ekpenyong M, Nyashanu M, Ossey-Nweze C, Serrant L. Exploring the perceptions of dignity among patients and nurses in hospital and community settings: An integrative review. J Res Nurs 2021; 26(6): 517-37. http://dx.doi.org/10.1177/1744987121997890 PMID: 35251226

[14] O'Lynn C, Cooper A, Blackwell L. Perceptions, experiences and preferences of patients receiving a clinician's touch during intimate care and procedures: A qualitative systematic review. JBI Database Syst Rev Implement Reports 2017; 15(11): 2707-22. http://dx.doi.org/10.11124/JBISRIR-2017-003375 PMID: 29135751

[15] Shakwane S. Untangling intimate care experiences for patients admitted to public hospitals in South Africa. Open Nurs J 2023; 17(1): e187443462302281.

http://dx.doi.org/10.2174/18744346-v17-230405-2022-169

[16] Sharifi S, Valiee S, Nouri B, Vatandost S. Investigating patients' attitudes toward receiving care from an opposite-gender nurse. Nurs Forum 2021; 56(2): 322-9. http://dx.doi.org/10.1111/nuf.12556 PMID: 33566392

[17] Asante AO, Korsah KA, Amoako C. Does the gender of nurses matter to patients? A qualitative analysis of gender preferences of patients. SAGE Open Med 2023; 11: 20503121231182514. http://dx.doi.org/10.1177/20503121231182514 PMID: 37456084

[18] Simonsson J, Keijzer K, Södereld T, Forsberg A. Intensive critical care nurses' with limited experience: Experiences of caring for an organ donor during the donation process. J Clin Nurs 2020; 29(9-10): 1614-22. http://dx.doi.org/10.1111/jocn.15195 PMID: 31971283

[19] Granja C, Lopes A, Moreira S, Dias C, Costa-Pereira A, Carneiro A. Patients' recollections of experiences in the intensive care unit may affect their quality of life. Crit Care 2005; 9(2): R96-R109. http://dx.doi.org/10.1186/cc3026 PMID: 15774056

[20] Murray MJ, DeBlock H, Erstad B, *et al*. Clinical practice guidelines for sustained neuromuscular blockade in the adult critically ill patient. Crit Care Med 2016; 44(11): 2079-103. http://dx.doi.org/10.1097/CCM.0000000000002027 PMID: 27755068

[21] Devlin JW, Skrobik Y, Gélinas C, *et al*. Clinical practice guidelines for the prevention and management of pain, agitation/sedation, delirium, immobility, and sleep disruption in adult patients in the ICU. Crit Care Med 2018; 46(9): e825-73. http://dx.doi.org/10.1097/CCM.0000000000003299 PMID: 30113379

[22] Puntillo KA, Morris AB, Thompson CL, Stanik-Hutt J, White CA, Wild LR. Pain behaviors observed during six common procedures: Results from Thunder Project II. Crit Care Med 2004; 32(2): 421-7. http://dx.doi.org/10.1097/01.CCM.0000108875.35298.D2 PMID: 14758158

[23] Intimate examinations and chaperones. 2024. Available from: https://www.gmc-uk.org/professional-standards/the-professional-standards/intimate-examinations-and-chaperones

[24] Anderberg P, Lepp M, Berglund A L, Segesten K. Preserving dignity in caring for older adults: A concept analysis. J Adv Nurs 2007; 59(6): 635-43. http://dx.doi.org/10.1111/j.1365-2648.2007.04375.x

[25] Baillie L. Patient dignity in an acute hospital setting: A case study. Int J Nurs Stud 2009; 46(1): 23-37. http://dx.doi.org/10.1016/j.ijnurstu.2008.08.003 PMID: 18790477

[26] Matiti MR, Trorey GM. Patients' expectations of the maintenance of their dignity. J Clin Nurs 2008; 17(20): 2709-17. http://dx.doi.org/10.1111/j.1365-2702.2008.02365.x PMID: 18808639

[27] Halligan P. Caring for patients of Islamic denomination: Critical care nurses' experiences in Saudi Arabia. J Clin Nurs 2006; 15(12): 1565-73. http://dx.doi.org/10.1111/j.1365-2702.2005.01525.x PMID: 17118079

[28] Meyfroidt G, Gunst J, Martin-Loeches I, *et al*. Management of the brain-dead donor in the ICU: General and specific therapy to improve transplantable organ quality. Intensive Care Med 2019; 45(3): 343-53. http://dx.doi.org/10.1007/s00134-019-05551-y PMID: 30741327

[29] Flodén A, Forsberg A. A phenomenographic study of ICU-nurses' perceptions of and attitudes to organ donation and care of potential donors. Intensive Crit Care Nurs 2009; 25(6): 306-13. http://dx.doi.org/10.1016/j.iccn.2009.06.002 PMID: 19608419

[30] Kentish-Barnes N, Siminoff LA, Walker W, *et al*. A narrative review of family members' experience of organ donation request after brain death in the critical care setting. Intensive Care Med 2019; 45(3): 331-42. http://dx.doi.org/10.1007/s00134-019-05575-4 PMID: 30840119

[31] Cohn S, Fritz ZBM, Frankau JM, Laroche CM, Fuld JP. Do not attempt cardiopulmonary resuscitation orders in acute medical settings: A qualitative study. QJM 2013; 106(2): 165-77. http://dx.doi.org/10.1093/qjmed/hcs222 PMID: 23185026

[32] Mockford C, Fritz Z, George R, *et al*. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders: A systematic review of the barriers and facilitators of decision-making and implementation. Resuscitation 2015; 88: 99-113. http://dx.doi.org/10.1016/j.resuscitation.2014.11.016 PMID: 25433293

[33] Al Farhan A, Al Harthi M, Bin Mosa M, *et al*. Patient reluctance to accept do not resuscitate order: Impact on clinical care. East Mediterr Health J 2020; 26(8): 933-8. http://dx.doi.org/10.26719/emhj.20.009 PMID: 32896888

[34] Cook D, Rocker G. Dying with dignity in the intensive care unit. N Engl J Med 2014; 370(26): 2506-14. http://dx.doi.org/10.1056/NEJMra1208795 PMID: 24963569

[35] Hamric AB, Blackhall LJ. Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. Crit Care Med 2007; 35(2): 422-9. http://dx.doi.org/10.1097/01.CCM.0000254722.50608.2D PMID: 17205001

[36] Morley G, Ives J, Bradbury-Jones C, Irvine F. What is 'Moral distress'? A narrative synthesis of the literature. Nurs Ethics 2019; 26(3): 646-62. http://dx.doi.org/10.1177/0969733017724354 PMID: 28990446

[37] Hiler CA, Hickman RL Jr, Reimer AP, Wilson K. Predictors of moral distress in a US sample of critical care nurses. Am J Crit Care 2018; 27(1): 59-66. http://dx.doi.org/10.4037/ajcc2018968 PMID: 29292277

[38] Alanazi MA, Shaban MM, Ramadan OME, *et al*. Navigating end-of-life decision-making in nursing: A systematic review of ethical challenges and palliative care practices. BMC Nurs 2024; 23(1): 467. http://dx.doi.org/10.1186/s12912-024-02087-5 PMID: 38982459

[39] Ntseke S, Coetzee I, Heyns T. Moral distress among critical care nurses when excecuting Do-Not-Resuscitate (DNR) orders in a public critical care unit in Gauteng. South Afr J Crit Care 2023; 39(2): 49-53. http://dx.doi.org/10.7196/SAJCC.2023.v39i2.511 PMID: 37547770

[40] The ICN code of ethics for nurses. 2021. Available from: https://www.icn.ch/resources/publications-and-reports/icn-code-ethics-nurses

DISCLAIMER: Please note that this article is currently in the 'Early view' stage and is not the final 'Version of Record'. While it has been accepted, copy-edited, and formatted, however, it is still undergoing proofreading and corrections by the authors. Therefore, the text may still change before the final publication. Although 'Early view' may not have all bibliographic details available, the DOI and the year of online publication can still be used to cite them. The article title, DOI, publication year, and author(s) should all be included in the citation format. Once the 'Final Version of Record' becomes available the 'Early view' will be replaced by that.