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Influences on Ethical Decision-Making by Nurses Employed in Federal Health Care Facilities

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Healthcare professionals are tasked with making key decisions involving new and controversial approaches such as organ transplantation and life-prolonging technologies and treatments that raise various ethical issues. Suboptimal ethical choices by nurses can lead to negative patient outcomes and lower the quality of life in federal healthcare facilities. The purpose of this nonexperimental quantitative correlational study was to identify the factors that influence nurses' ethical decision-making processes in U.S. federal healthcare facilities. The theoretical framework was based on Beauchamp and Childress' ethical system of principlism. Three research questions addressed the nature and extent of the relationship between nurses' Ethical Behavior Test (EBT) scores and personal experiences, professional experiences, and professional ethics training. A quantitative correlational design using the EBT questionnaire to collect data from a convenience sample of 381 nurses. Data analysis included descriptive statistics and multiple linear regression at the 0.05 significance level. Findings indicated a significant relationship between EBT scores and personal experiences ($p < 0.0001$), professional experiences ($p < 0.0001$), and professional ethics training ($p < 0.015$). In conclusion, professional ethics training and personal and professional experiences significantly predicted nurses' ethical behaviors. Professional training for nurses in ethical decision-making is recommended to allow them to effectively apply ethics in clinical practice. Implications for social change include informing nursing educators and public health policymakers of these influences so they can design interventions.

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Dedication

To my daughters Melanie and Nicole Blount

To the living and deceased who have inspired me

A very special thanks to Marcellus N. Hughes and Sylvia Hughes I thank you deeply for the Faith, Love, and Hope over the years we were together.

A special thanks to Brigitte L. Greissl-Blount who made it all possible.

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"Education is the only way, into the glorious light" (Forest Whitaker, 2015).

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Chapter 1: Introduction to the Study

Nursing practice not only necessitates an understanding of healthcare, but also involves delivery of treatment to patients. In the nursing context, treatment of people is not limited to delivery of care but also refers to the manner in which nurses and other clinical staff interact with and care for patients. In addition to involving the provision of medical attention, nurses' ability to treat patients also entails clinical decision-making that is informed by continuous evaluation of the ethical implications of patient-centered practices. The study explored ethical decision-making by nurses working in federal healthcare facilities in the United States. Nurses are closely involved in patient-centered practices, which entail decisions that have ethical implications. Nurses' ethical decisions revolve around the definition and provision of optimal care. These decisions have a direct impact on the quality of care and patient health outcomes.

Chapter 1 includes the background of the study, which briefly summarizes previous literature regarding nurses' ethical decision-making. This chapter also includes a problem statement, the purpose of the study, research paradigm, significance, research questions, and hypothesis. Also, the research design, theoretical foundation, assumptions, limitations, delimitations, and definitions of key terms are presented in this chapter.

Background of Study

Nurse-patient interactions are complex because people have different personal, educational, and professional backgrounds and perceptions about their experiences. These experiences involve the role of nurses in providing care and patients' willingness

to accept care for sensitive health conditions including injuries as a result of violence, genetic problems, mental health and substance abuse. Thus, further research on nurses' ethical decision-making processes is needed to ensure improvement in the quality of care.

The healthcare sector is comprised of physicians, administrators, government agencies, and health maintenance organizations that have a mandate to provide healthcare. As a result, ethical dilemmas are bound to occur. Ethical dilemmas in patient care can be difficult for nurses, especially when the hypothetical problems they studied during training become real. Nursing involves making decisions about moral dilemmas and this can cause in mental and emotional distress for nurses. For example, when patients' wishes conflict with a nurse's professional ethics, such as when a patient who is in medical isolation under physician orders pleads with the nurse to allow her child to visit her in the isolation unit. These conflicts can cause nurses to violate professional ethics, leading to suboptimal quality of health care.

A hierarchy of clinical decision-making exists in medicine, in which nurses are required to implement physicians' orders without question (Kvist, Voutilainen, Eneh, Mäntynen, & Vehviläinen-Julkunen, 2019). While nurses spend a lot of time providing care to patients, physicians may only visit a patient for a few minutes a day (Grace, 2018; Koskenvuori, Numminen, & Suhonen, 2019; Lehmann, Sulmasy, & Desai, 2018). Nurses are usually motivated to help patients, as they care for them when they are at their most vulnerable. Nurses are ethically obligated to provide the best care possible despite challenging circumstances such as time constraints, staff shortages or limited resources (Beks, Healey, & Schlicht, 2018; Griffiths, 2019; Ion, DeSouza, & Kerin, 2018; Iserson,

2018; Johnsen, Fossum, Vivekananda-Schmidt, Fruhling, & Slettebø, 2018; Khatiban, Falahan, Amini, Farahanchi, & Soltanian, 2018). A review of the literature revealed many recent studies on nurses' ethical choices, but no studies on ethical choices made by nurses working in federal healthcare facilities. Federal healthcare facilities include hospitals and clinics that operate under the authority of the federal government of the United States, serving retired and active members of the Marines, U.S. Army, Air Force, Navy, and Coast Guard. Each federal healthcare facility operates under the auspices of one of four departments: the Department of Defense, Department of Health and Human Services, Department of Homeland Security, and Department of Veterans Affairs.

Since so many US service members depend on federal health care facilities for care, research regarding the factors that influence nurses' ethical choices within federal healthcare facilities would support the quality of nursing care for service members. Nurse educators and healthcare policy makers could gain an improved understanding of the factors influencing nurses' ethical dilemmas and related choices while providing care with federal healthcare facilities, which could possibly lead to interventions to prevent violations of nursing ethics. Nurses may feel supported, and therefore reducing the risk of health complications related to lower quality of patient care in federal health care facilities.

Problem Statement

The problem addressed by this study was that ethical violations by nurses can lower the quality of care in federal healthcare facilities. Federal healthcare facilities operate under the direct authority of the US government, while supervision of public and

private healthcare facilities is performed by a variety of regulatory, nonprofit, and for-profit entities. Since many Americans are eligible to receive care through federal healthcare facilities, including all service members in the Army, Navy, Air Force and Coast Guard, the ethical choices that nurses make while working in facilities warrant examination. Ethical issues are bound to occur within any healthcare institution where moral questions regarding right or wrong form the basis of professional decision-making and liberal care of patients (Davidson, Mendis, Stuck, DeMichele, & Zisook, 2018; Swinglehurst & Hjörleifsson, 2018; Taylor et al., 2018; Tsuruwaka, & Asahara, 2018; Valeberg, Liodden, Grimsmo, & Lindwall, 2018; Wexler, 2018). The most common ethical dilemmas involve nurses' decisions regarding pain control, quality of life, and cost constraints (Barlem & Ramos, 2015; Conradi, 2015; Raines, 2000; Stolt, Leino-Kilpi, Ruokonen, Repo, & Suhonen, 2018; Sullivan & McCoy, 2018. Changes in coverage and cost of healthcare have also resulted in the dominance of rational and economic values in care delivery which may conflict with best interests of patients (Conradi, 2015; Coverston & Rogers, 2000).

Nursing practice is generally faced with the challenge to make choices that support efficiency of the health care facility while comprising of violations of nursing ethics which may result in harm to patients (Hashish & Awad, 2019; Raines, 2000). Ethical considerations play a major role in the provision of quality healthcare for nurses (Barlem & Ramos, 2015; Wihastuti, Rahmawati, Rachmawati, Lestari, & Kumboyono, 2019; Williams & Anderson, 2018). Human action is normally based on a combination of emotional and logical considerations. Though nurses are guided by a professional code of

conduct, these rules originate from high-level beliefs about justice, beneficence, and fairness (Kangasniemi et et al., 2015). Nurses must make ethical choices about the quality of patient care they will provide while confronting staff shortages, cost considerations, and time constraints (Kangasniemiet et al., 2015; Sofronas, Wright, & Carnevale, 2018). This focus was chosen due to a gap in the research regarding nurses working in federal healthcare facilities specifically.

Sometimes, healthcare facilities encourage nurses to implement practices that reflect considerations for saving on costs and the efficiency of the facility rather than the best interests of the patient (Barlem & Ramos, 2015). Nurses' ethical decision-making processes can sometimes collapse due to various personal and professional factors. Disruption of ethical decision-making processes by nurses is a major issue as it can affect patients' well-being and quality of care (Barlem & Ramos, 2015; Gardenier, Miller, & Wheeler, 2018).

Purpose of the Study

The purpose of this nonexperimental quantitative correlational study was to identify factors that influence ethical decision-making processes by nurses working in federal health care facilities in the United States. Data were obtained through the Ethical Behavior Test (EBT) questionnaire. The EBT is a standard survey tool that is designed to collect Likert-scale data regarding daily ethical dilemmas in nursing practice (Dierckx de Casterlé et al., 1997). The EBT has two case studies showing nurses in daily ethical dilemmas. Participants were asked to answer four multipart questions for each case study: (a) most desirable solution to each situation, (b) why or why not to tell the truth, (c)

work-related factors for telling the truth, and (d) opinions about their choices. The four questions evaluated the participants' ethical practice, ethical reasoning (ER), and perceptions regarding the nursing dilemma In addition to the two case studies, the third set of questions in the EBT survey (work-related factors for telling the truth) provided four scenarios that challenged the participant to implement decisions.

The scenarios contained statements that corresponded to stages 1-4 of the Kohlberg (1981) ethical model. Kohlberg (1976) identified three levels of moral development in relation to the ethical decisions that adults make over the course of their life: preconventional, conventional, and postconventional. The moral development framework pertains to whether the individual has the ability to reflect on their ethical choices independently from conventional norms. The individual who progresses to postconventional morality is willing to act on their own principles regardless of external pressures (Kohlberg, 1981). The ER score for each nurse participant ranging from 5 to 55 points, was calculated based on the participants' preference for post-conventional as opposed to pre-conventional arguments when making ethical decisions. A high ethical reasoning score indicated the participants' intention to adhere to ethical principles regardless of external pressures.

The findings of the study will contribute to understanding how personal and professional experiences and professional education influence ethical decision-making processes among nurses working in federal healthcare facilities. The key study variables involved influences on the process of making ethical choices while providing care. These

included professional experiences, professional training, personal experiences, major factors affecting ethical decision-making, and ethical choices.

Significance of the Study

Though extensive research on the clinical impact of nursing ethics exist, few studies have addressed the relationship between ethical decision-making processes and the quality of care offered by nurses. Limited research may be due to lack of clear definitions of ethical practices in relation to the professional experiences of nurses in literature. Ethical conflicts are common when professional norms such as requirement for nurses to assist with abortion or physician-assisted suicide appear to contradict nurses' personal beliefs and ethics. Potential implications for positive social changes include contributions to nurse education, so that interventions can be designed to prevent ethical violations by nurses while providing care. The study may also contribute informative perspectives for nursing administrators to use when implementing interventions to prevent nurses from engaging in violation of nurse ethics while providing care.

Significance to Practice

Implications of the study for positive social change involve professional training for nurses working in federal health care facilities that specifically addresses the risk of ethical violations while providing care. Nurse educators and healthcare policy makers may gain an increased understanding of the factors that influence the choices that nurses make when they experience ethical conflicts while delivering care. This may support interventions that would support clinicians and reduce risks of complications and negative influences on the quality of patient care and health outcomes. As healthcare

professionals, nurses must adhere to government regulations and professional codes of ethics. Any conflicts between requirements to follow government regulations and nurses' professional code of ethics can cause stress for nurses during care delivery. A nurse's internal conflict about quality of patient care issues can potentially lead to violation of nursing ethics and lower quality of patient care (Kangasniemi et al., 2015). Such conflicts can also negatively impact health care consumers' perceptions of the quality of care in federal healthcare facilities.

Significance to Theory

Nurses' ethical decision-making processes must be understood to ensure that appropriate clinical decisions are made while addressing various patient care concerns. Understanding nurses' ethical decision-making processes during patient care can facilitate competent care provision and the development of public policies regarding healthcare delivery. The study is particularly significant because no studies have examined ethical decision-making processes by nurses working in federal healthcare facilities.

Significance to Social Change

The current project can lead to significant positive social change in practice. Findings from this project could guide policymakers' decision-making regarding the training of nurses to make ethical decisions. Ethical decision-making processes by nurses in federal healthcare facilities are important for public health policy because these choices may sometimes involve complex issues such as rationing of care or physician assisted suicide, which are heavily regulated (Gamondi, Borasio, Oliver, Preston, &

Payne, 2019). Kangasniemi et al., 2015; Rooddehghan, Yekta, & Nasrabadi, 2018). Additionally, nurses' choices can impact peers, patient outcomes, and the quality of services in healthcare institutions (Demeh & Rosengren, 2015). Since many Americans receive care at federal healthcare facilities, including members of the Army, Navy, Air Force and Coast Guard as well as retired military service members, ethical choices that nurses make while working in the facilities warrants examination. Issues regarding ethical decision-making processes among nurses can negatively affect the entire federal healthcare sector. Findings from this project could also be used to improve care outcomes among patients with complex health conditions by empowering nurses to make critical and moral decisions.

Research Questions

The aim of the research was to answer the following questions:

RQ1: Do nurses' professional experiences affect their ethical decision-making when working in federal healthcare facilities?

$H_0$1: Nurses' professional experiences do not affect their ethical decision-making when working in federal health care facilities.

H_a1: Nurses' professional experiences do affect their ethical decision-making in federal healthcare facilities.

RQ2: Does professional nurses' training in personal ethics affect their ethical decision-making when working in federal healthcare facilities?

$H_0$2: Professional nurses' training in personal ethics does not affect their ethical decision-making in federal healthcare facilities.

H_a2: Professional nurses' training in personal ethics does affect ethical decision-making in federal healthcare facilities.

RQ3: Do professional nurses' personal experiences affect their ethical decision-making in federal healthcare facilities?

H_03: Professional nurses' personal experiences do not affect their ethical decision-making in federal healthcare facilities.

H_a3:Nurses' personal experiences do affect their ethical decision-making in federal healthcare facilities.

Research Design

The study employed a nonexperimental approach. Quantitative Likert-scale data were collected using the EBT questionnaire. Bernadette Dierckx de Casterlé, one of the authors of the EBT, provided written permission to use it for this study (see Appendix A). A Likert-scale questionnaire was used to facilitate the collection of opinion-related data from nurses working in federal healthcare facilities . The study involved a random sample of 381 nurses working at federal healthcare facilities in the United States. A quantitative research design was chosen to ensure the collection of objective data, which could facilitate the identification of sub-optimal decision-making by nurses which could cause ethical issues. The research design was selected to identify the relationship between nurse training practices and ethical decision-making practices among nurses in federal healthcare facilities. The rationale for selecting a quantitative research design was to ensure objectivity and reliability of the findings. The use of the EBT ensured collection of participants' responses based on items that elicited critical thinking regarding nurses'

ethical decision-making processes. The data was analyzed using correlational tests. Correlation tests were used to identify associations between the control variables involving professional experiences, professional training, and personal experiences and the dependent variable of ethical decision-making among nurses working in federal healthcare facilities as shown in responses on the EBT. An ordinal regression model was used to address the extent to which professional experiences, professional training and personal experiences influenced ethical decision-making among nurses in federal health care facilities in the United States.

Theoretical Framework

The theoretical framework for the study was Kohlberg's theory of moral development. Kohlberg (1976) identified three levels of moral development in relation to the ethical decisions that adults make during the course of their life: Preconventional, conventional, and postconventional. Each level involves two stages, with the second stage indicating greater moral development (Kohlberg, 1981). Figure 1 shows a framework based on Kohlberg's theory of moral development.

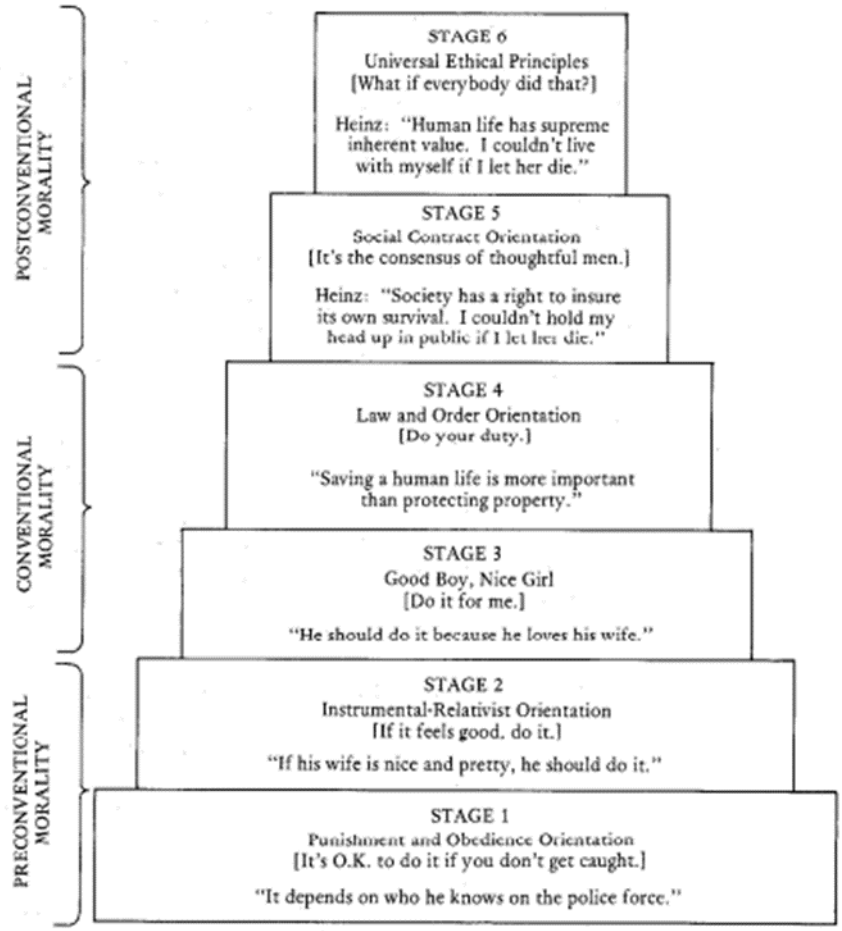

Figure 1. Kohlberg's theory of moral development.

The structure of the moral development framework pertains to whether the individual is able to reflect on their ethical choices independently from conventional norms. The framework shows that a person at the preconventional level is unable to view moral choices in terms of conventional norms. Instead, they make choices based on fear of punishment or self-aggrandizement. An individual whose moral development has reached a conventional level makes choices according to what significant others in their environment will think. They desire to conform in order to avoid discomfort or ostracism, and act out of loyalty and obedience to social norms. The individual who progresses to

postconventional morality is willing to act on principles that are relevant to their personal values and what they believe is most important in life.

Lawrence Kohlberg developed the theory of stages of moral development as a variation on a psychological theory that originated with Swiss psychologist Jean Piaget. Piaget (1932) proposed that the individual's capacity for logic and moral judgment occurs as the outcome of a series of constructive stages of growth. Kohlberg expanded on Piaget's theory and concluded that moral development was a process that was mainly based on the concept of justice. According to Kohlberg (1973), moral development was a process that could continue throughout a person's entire life.

Yildiz (2019) noted that although professional ethics are fundamental to the nursing profession, few studies have focused on professional ethics in nursing. Kim and An (2017) compared attitudes of undergraduate nursing students toward privacy in regard to social networks in the context of Kohlberg's theory of moral development and concluded that the students largely adhered to conventional morality rather than the postconventional level of development. The theoretical framework for this study was selected due to its use as the foundation for the EBT test. The research questions for this study pertain to the influence of personal characteristics and experiences on ethical choices made by the nurse participants on the EBT.

Nature of the Study

The nature of this study was a quantitative nonexperimental survey using the EBT. This design was selected to explore the ethical reasoning (ER) of nurses employed at federal healthcare facilities in the United States. The key study variables involved

influences on the process of making ethical choices while providing care. These included: professional experiences, professional training, personal experiences, major factors affecting ethical decision-making, and ethical choices as shown on the EBT. The study employed a correlational research design to examine the extent to which professional training, professional experiences, and personal experiences affected ethical decision-making processes among nurses working in federal healthcare facilities. After collection, the data was coded and statistically analyzed using the SPSS software version 22.

The EBT measures the ethical responses of nurses in the context of delivering patient care within Kohlberg's theory of moral development (Kohlberg, 1981). Kohlberg (1964) defined moral development as "the capacity to make decisions and judgments which are moral (i.e. based on internal principles) and to act in accordance with such judgments" (p. 425). Each level involves two stages, with the second stage showing greater moral development (Kohlberg, 1981). The levels are distinguished by the ways that the individual conforms to conventions in making ethical decisions. According to Kohlberg (1976), conventions are social norms, rules, expectations, and laws that are relevant to the individual's ethical decisions.

The authors of the EBT refined Kohlberg's concept to include the care perspective of nursing, specifically for nurses' commitment to quality of patient care. The instrument has been used to examine nursing students' ethical behavior in five nursing dilemmas. Ethical behavior refers to ethical reasoning as well as reasoning related to behavior (de Casterlé et al., 1997). The results show that the majority of students acted according to a conventional level of moral development, in which the individual

conforms to external expectations about their ethical choices (de Casterlé et al., 1997). Data analysis was performed using tables and graphs. Participants' responses were coded to reflect whether they selected postconventional solutions as opposed to procedure-based reasons for each scenario on the EBT.

Dependent and Control Variables

A dependent variable is a measure of interest that is influenced by independent factors (Flannelly, Flannelly, & Jankowski, 2014). The dependent variable in this project was the nurses' ER as shown in scores on the EBT, which was calculated through the ranking of dilemmas based on importance. A control variable is a factor that does not change while influencing or causing change to the dependent variable (Flannelly et al., 2014). In this project, the control variables included personal experience, professional experiences, and professional training in personal ethics. The internal influencing independent variables were age, gender, and working environment. The variables were measured by the ER score on the EBT for each nurse participant ranging from 5 to 55 points. The ER was calculated based on the nurse participants' preference for post-conventional as opposed to pre-conventional arguments when making ethical decisions. A high ethical reasoning score indicated the nurse participants' intention to adhere to ethical principles regardless of external pressures.

Assumptions

The study was guided by three primary assumptions. First, it was assumed that ethics are valuable components of human interaction and decision-making by health

professionals, specifically nurses working in federal health facilities. Secondly, it was assumed that ethical decision-making is complex and can be further complicated by environmental factors including staffing shortages, time constraints, and budget restraints. These influences can significantly affect nurses working in federal health care facilities and increase the risk that they will violate nursing ethics have negative effects on their ability to deliver quality care (Kangasniemi et al., 2015).

Limitations

The first limitation of the study was that the use of a convenience sample reduced the generalizability of the findings. Generalizability was reduced since not all nurses working in federal health care facilities were surveyed and the sample population may not be representative of the study population of all nurses working in federal health care facilities. Though the EBT is a valid and reliable tool for collecting data on attitudes and opinions regarding ethical decision-making, cultural distinctions in populations could significantly affect nurses' attitudes regarding the topics in the test. Since the sample population did not include nurses from every culture, the applicability of the study results was limited to the nurses surveyed. Since the establishment of the EBT, significant changes in attitudes about treatment options have occurred and public policy is evolving in response. For example, assisted suicide is now permitted in the United States under some circumstances (Gamondi et al., 2019). Nurses working in federal health care facilities may not be comfortable participating in the practice. Thus, the validity of the EBT can be decreased for problems described in case studies on which the instrument is based. Lastly, the EBT survey was administered at a single point in time rather than

implemented longitudinally. Consequently, the test may not fully capture variations in participants' attitudes and opinions that can occur over time. These limitations may also reduce the generalizability of the study.

Researcher Bias

Researcher bias was minimized through use of a validated survey instrument over which the researcher did not have influence. The EBT is a survey instrument, and responses to the EBT were scored using a Likert scale that was not influenced by the researcher. The survey was administered anonymously online to minimize potential researcher bias. The researcher did not meet study participants face to face, and could not influence the participants' responses to the EBT questions. Risk of researcher bias while interpreting the findings was minimized by scoring of the EBT results using a Likert scale.

Delimitations

The study had various delimitations imposed by the researcher. First, all participants were nurses who worked at a federal healthcare facility, but not all nurses employed in federal health care facilities were surveyed due to time and cost constraints. The three major types of degreed nurses are the registered nurse (RN), licensed practical nurse (LPN), and nurse practitioner (NP). Participants in the study were required to possess at least one of these degrees from an accredited program and were licensed to practice nursing. Participants were not allowed to participate in the study if they were recipients of care at the facility in which they worked at the time of the study in order to avoid conflicting experiences involving nurses as patients as well as caregivers. The

inclusion of participants with nursing degrees who are employed in federal healthcare facilities facilitated the collection of robust data that may show variations in terms of ethical decision-making based on degree type. Recruitment of participants was conducted via LinkedIn and Instagram using convenience sampling.

Definition of Terms

The key terms for the study are as follows:

Administrator: A healthcare professional who manages a healthcare facility and performs care-based bureaucratic tasks and decision-making tasks (Hunink et al., 2014).

Ethical behavior test (EBT): The EBT is a standard survey tool that is designed to collect Likert scale data regarding daily ethical dilemmas in nursing practice (Dierckx de Casterlé et al., 1997).

Ethical decision-making: The emotional and cognitive process of using different information to make care decisions during regular nursing and medicine practice (Barlem & Ramos, 2015).

Federal healthcare facilities: Health care facilities include hospitals, primary health care centers, clinics, and long-term geriatric care residential centers (nursing homes) that operate under the authority of the federal government of the United States (World Health Organization, 2018).

Moral distress: Temporary or prolonged mental anguish that people feel when they must make ethical decisions (Sasso et al., 2015).

Nurse: A licensed health professional who performs an auxiliary role for a physician (Cigman, 2013). In the context of the study, a nurse is defined as an individual who has earned credentials and licensure as a RN, LPN, or NP.

Personal ethics: Personal ethics are rules and behaviors that originate from an individual or collective understanding of right versus wrong decisions (Beauchamp, 2016).

Physician: A licensed healthcare professional who owns a medical degree and has satisfied legal and professional requirements for practicing medicine (Hunink et al., 2014).

Professional ethics: A collection of principles and behaviors that stem from an individual's professional understandings of right versus wrong decisions (Kangasniemi et al., 2015).

Supervisor: A healthcare professional who is tasked with overseeing practices conducted by a physician or nurse (Dawson, 2014). Though supervisors have administrative rather than medical backgrounds, they can nevertheless oversee nurses and physicians.

Summary

Chapter 1 introduced the study, which included a background, problem statement, purpose of the study, research questions, significance, assumptions, limitations, and delimitations. This chapter also provided a comprehensive overview of the theoretical framework, hypotheses, and definitions of key terms that were used throughout the study. This study involved an evaluation of ethical decision-making processes by 381 nurses

working in federal healthcare facilities in relation to their individual experiences, professional experiences, and professional training in professional ethics. A quantitative nonexperimental correlational design was used with an EBT survey to evaluate ethical decision-making processes for nurses working in federal healthcare facilities in the United States. The findings of the study will provide understanding to health care policy makers, nurse educators and nurse administrators about how individual experiences, professional experiences, and professional training in professional ethics of nurses working in federal health care facilities influence their ethical decision-making processes. Chapter 2 will provide a comprehensive review of extant literature regarding nursing ethics, moral conflicts, medical ethics, ethical sensitivity, biomedical ethics, ethical conflicts, and principlism as they pertain to the ethical decision-making of nurses. The literature review identifies a gap in existing literature which the study addressed.

Chapter 2: Literature Review

The problem addressed by this study was that ethical violations by nurses can lower the quality of care in federal healthcare facilities. The purpose of this nonexperimental quantitative correlational study was to identify the factors that influence ethical decision-making processes by nurses working in federal healthcare facilities in the United States. This chapter provides a review of existing literature related to nurses and ethical decision-making, moral choices, and medical ethics in the federal health care environment. Studies provide comprehensive and plentiful information regarding factors that influence nurse ethics while providing care.

The chapter starts with the literature search strategy and theoretical and conceptual frameworks. Other sections included in this literature review include ethics in biomedical decision-making, ethical dilemmas in nursing, medical education ethics, bureaucratic ethics, commitment to the group, group influence on ethics, and ethical competence. The literature review section also contains topics related to ethical decision-making: nursing leadership, nurses' gender, nurses' education level in terms of ethical decision-making, generational factors, and length of employment. The literature review was developed to effectively synthesize collected information. In the conclusion, this researcher indicates ways by which the study may contribute to the gap in existing studies.

Literature Search Strategy

An extensive search for peer-reviewed articles was conducted using keywords: *nursing ethics, medical ethics, biomedical ethics, nurse ethical sensitivity, nurse ethical*

conflict, *nurse moral conflict*, and *principlism*, *nurse ethical conflict*, *nurse burnout*. The inclusion criteria for journal articles in the study were that they were published in peer reviewed journals after 2012 and were relevant to the topic under study. Journal articles were derived from the academic databases Google Scholar, PubMed, PMC, ResearchGate, and EBSCO. To find sources, settings of databases were adjusted so that only peer-reviewed journal articles published after 2012 were revealed after inserting search terms. Forty-nine journal articles were reviewed and information from 19 journal articles was used to enhance concepts in the main sources. The studies contained information related to nurses and ethical decision-making, moral choices, and medical ethics in a variety of clinical settings, such as disaster nursing, medical emergency, nursing homes, and Intensive Care Units (ICUs).

Theoretical Foundation

The theoretical framework of this study was Beauchamp and Childress' ethical system of principlism. Prior development of principlism was based on the Hippocratic tradition that emerged from homogeneous societies in which members of the community shared similar beliefs and values. The main emphasis of the Hippocratic tradition was on gentlemanly conduct, virtue, and duty (Magill, 2015). The main components of principlism are four prima facie principles that guide medical ethics which are autonomy, beneficence, nonmaleficence, and justice. Autonomy requires that patients have the right to make their own decisions and beneficence means that practitioners should act with the interest of patients in mind. The nonmaleficence principle requires that practitioners

should not harm patients and the justice principle emphasizes equality and fairness among individuals (Hammersley, 2015).

The values inherent in the four principles are consistent with moral norms, and thus are important in ethical decision-making during practice. The four principles have been used in medical ethics since 1974. Principlism originated as the moral decision-making framework of medical research as a result of the National Research Act of 1974 (Pub. L. 93-948). The United States Congress enacted this law partly in response to egregious ethical violations committed by medical researchers during the Tuskegee syphilis research study of 1932-1972. The Act created the National Commission for the Protection of Human Subjects of Biological and Behavioral Research to supervise medical experimentation on human subjects in which the four principles are followed. The four principles are also foundational guidelines in the Nightingale Pledge for nurses and Hippocratic Oath for physicians (Holmboe & Bernabeo, 2014).

Though principlism is important in ethical decision-making, practical applications of principles collectively in a real situation are challenging. Moral decisions involve dilemmas because the individual making the choice can be morally right or wrong according to particular principles. Also, the choice that the individual makes may conflict with other moral principles (Abimbola, 2013; Bah & Sey-Sawo, 2018). Decision-making that is dilemmatic is common in pluralistic social situations. Principlism can be modified through adding or subtracting component principles. However, the four principles of beneficence, justice, nonmaleficence, and autonomy are comprehensive

enough to cover most dilemmatic situations and will provide necessary guidelines for developing interdisciplinary moral decisions.

The purpose of this nonexperimental quantitative correlational study was to identify the factors that influence ethical decision-making processes of nurses working in federal healthcare facilities in the United States. The study was guided by research questions about the which influence ethical decision-making for nurses in federal health care facilities, healthcare setting, making principlism theory appropriate in developing the study. Principlism has been widely adopted as ethical guidelines that have a direct application to care delivery. The research questions related to the theory since the central concern was medical ethics.

Literature Review Related to Key Concepts and Variable

While nurses make choices related to nursing ethics in clinical settings, little is known about elements of ethical decisions in clinical settings. The purpose of medical ethics is to guide biomedical and clinical research, advance development of new ideas in the field, direct formulation of policies in healthcare, and contribute to clinicians' education. Therefore, good medical ethics need to be coherent, measured, informed, consistent, reasonable, and illuminating. Poor medical ethics are incoherent, nonilluminating, inaccurate, unreasonable, inconsistent, and not measured. With regard to coherence, medical ethics need to expressive in terms of what is regarded as good medical practice. Regarding the quality of being illuminating, good medical ethics should involve clear directions to be followed wherever clinicians encounter dilemmas in decision-making. Good medical ethics need to serve as guidance to decency in practice

among service providers to meet purposes of being accurate (Rhodes, 2014). The element of reasonability in good medical ethics requires that rules should be simple to understand for professionals to avoid mistakes.

Richer (2014) said that clinical ethics consultations should be problem-centered and realistic. The process should also be structured to enable conflict management in a legal framework to resolve normative problems in patient care. Unlike other medical consultants who can make decisions independently, clinical ethicists need to consult with other stakeholders. Therefore, clinical ethics consultations need to enhance shared clinical decision-making that includes all parties such as the patients, relatives of the patient, and clinicians (Richter, 2014). Ethics consultation was founded by clinical ethics consultation groups to respond to situations that were ethically problematic. Ethics liaison service in ethics case consultations helps in minimizing ethical dilemmas and prevents ethical issues among patients (Bartholdson, Molewijk, Lützén, Blomgren, & Pergert, 2018). The advantage of clinical ethicists in normal ward rounds is that it enables early identification of minor ethical challenges and accommodates dynamic clinical and ethical goal setting during patient care. The presence of clinical ethicists in daily clinical routine also enhances continuous ethical education among staff and empowers the practitioners to appropriately deal with ethical issues by themselves. The proactive approach of the ethics liaison service significantly contributes to preventive ethics in minimizing ethical problems to meet the satisfaction of all stakeholders (Richter, 2014).

Truog et al. (2015) stated that medical ethics is important in medical education, therefore, most schools have incorporated it in the courses. Medical ethics is an extensive

field of study, but moral philosophy dominates in the content that focuses on ethical dilemmas. Educators for medical ethics rely on case-based approach in teaching ethics based on theories that are derived from moral philosophy such as deontology, principlism, and consequential. Truog et al. (2015) indicated that the case-based approach of teaching ethics is not so effective in capturing all ethical considerations that are encountered during practice. Therefore, the traditional model of teaching medical ethics needs to be complemented with an approach that involves ethics of daily clinical practice.

Svenaeus (2014) reviewed literature to investigate empathy as a necessary condition of phronesis. Svenaeus (2014) suggested that doctors need to be empathic to be good practitioners. Being empathic enables the doctors to understand and feel the patients' wishes and needs, thus use the best approach in helping them that comprises of ethical and medical sense. Though empathy is important to patient care, most authors have not clearly defined the subject, therefore, most practitioners do not understand it. Some authors that view empathy as sympathy, caring personality, or emotion contagion have not linked it to medical ethics that involves beneficence and autonomy. Svenaeus (2014) theorizes that empathy is the source and basic condition of moral knowledge because it is the feeling component in phronesis and the motivation for behaving in a good way. The Aristotelian concept of phronesis can be applied to doctors making decisions based on an emotional response to a patient, which sometimes leads to non-objective judgments. Though empathy is emotional reasoning, doctors need to consider risks of errors involved in the process. Additionally, doctors can empathize more

accurately by striving to be self-aware which helps them avoid projecting their unacknowledged emotions on the patients (Svenaeus, 2014).

Cigman (2013) stated that the implicit foundation for ethics in medical schools is that students need to be taught how not to act and how not to think, in order to avoid professional sanctions or lawsuits. However, the importance of practicing within professional guidance and the law focuses on risks that patients are exposed to and caused by practitioners after violating guidelines, instead of the necessity of treating patients humanely. The purpose of Cigman's (2013) study was to explore the relationship between learning how not to act or think as a doctor and learning how to be responsive and reflective to patients as human being. Cigman (2013) suggested that doctors need to exercise ethical thinking in order to provide appropriate care to patients as fellow human beings. De Oliveira et al. (2015) indicated that the exposure to unprofessional and unethical behavior significantly contributes to the declining empathy that medical students experience during their training. De Oliveira et al. (2015) conducted a literature review study to investigate the reasons that medical schools tolerate unethical behavior by medical students. The reasons for unprofessional behavior in medical schools are barriers to reporting unethical behaviors in medical schools such as lack of anonymity and fear of retaliation; directors and deans may be reluctant to investigate unethical behavior among colleagues; most professionals have learned to be ignorant about disrespectful circumstances in the health care institutions; accreditation of medical schools worldwide does not cover outcomes that foster ethical behaviors in students (de Oliveira et al., 2015).

Ethical Dilemmas in Nursing

Laerkner, Egerod, and Hansen (2015) conducted a qualitative explorative study to investigate nurses' experiences in caring for patients that are critically ill and non-sedated who require mechanical ventilation. The setting of the study was two ICUs in Denmark and it involved 13 months of fieldwork. The source of data for the study was participant observation and responses of 16 nurses that were interviewed. The collected data was analyzed through thematic interpretive description. The main theme that emerged after data analysis was that caring for intubated patients that are more awake was both demanding and rewarding. Caring for the patients was demanding because it resulted in unpredictable, complex actions, and ambiguous needs, and it was rewarding because it caused personalized interaction between the patient and the providers (Laerkner et al., 2015). Other minor themes that were identified included caring for the patient, negotiating instrumental and rational care, and managing emotional and physical closeness. Based on the findings, Laerkner et al. (2015) concluded that care is complex but nurses preferred to provide service to awake patients rather than those who were sedated. In addition, nurses prefer offering appreciated care for one patient at a particular time. The importance of collaboration between doctors and nurses is to ensure that the comfort of the patient during mechanical ventilation is achieved. Also, caring for non-sedated patients that are more awake required nurses to act at the interface between needs and ambiguous possibilities, which they viewed as both rewarding and demanding (Laerkner et al., 2015).

In a qualitative study using semi-structured interviews, Dwarswaard and Van de Bovenkamp (2015) investigated nurses' perceptions towards patients' self-management. Dwarswaard and Van de Bovenkamp (2015) state that policy makers have focused their attention on enhancing patients' self-management without critically reflecting on the trend. Focusing on self-management changes the values underlying the relationship between the nurse and the patient, which results in ethical dilemmas. Participants in the study included 15 nurses and six experts on medical ethics and self-management. Dwarswaard and Van de Bovenkamp (2015) found out that nurses providing self-management support were at risk of facing three types of ethical dilemmas which included: Stimulating patient involvement verses respecting their autonomy, reaching optimal health outcomes verses respecting patient autonomy, and maintaining professional boundaries verses an all-inclusive approach to self-management support. Based on the results, Dwarswaard and Van de Bovenkamp (2015) concluded that the ethical dilemmas that nurses experience are based on different views about the components of good self-management and care provision. Nurses tend to influence patients' decisions such as choosing the right option among alternatives or being actively involved. The study has impact on practice because self-management support can lead to clashing values. Therefore, developing and implementing self-management support needs the values pertaining to the relationship between patients and professionals to be deliberated (Dwarswaard & Van de Bovenkamp, 2015).

Gonzalez-de Paz, Kostov, Zabalegui-Yarnoz, and Siso-Almirall (2014) conducted a cross-sectional study to assess the level to which professionals in primary health care

approve ethical standards from norms. Ethical behavior health is among normative ethics which health care professionals need to advocate for in their daily practice, thus the importance of studying ethical sensitivity of nurses to the norms or the code of conduct (Milliken, 2018; Newham, 2019; Östman, Näsman, Eriksson, & Nyström, 2019). Gonzalez-de Paz et al. (2014) used a sample of 452 health care professionals from 56 hospitals in their study and data was collected through questionnaires. The level of ethical endorsement of items contained in the questionnaire and ethical performance of the health care professionals was examined using Rasch multidimensional model. The participants were grouped based on their sex, knowledge of ethical norms, and profession. Ethical performance between the groups was analyzed. One of the findings is that the level of ethical performance was lower in the items that related to respect to patient choices and patient autonomy. Also, professionals found it challenging to avoid interruptions whenever they saw patients. Gonzalez-de Paz et al. (2014) also found out that nurses had effective knowledge about ethical norms and practiced more ethically compared to family physicians and professionals. Based on the results, paternalistic behavior is persistent in Primary Health Care (PHC) and that patient autonomy and patient-centered care are not wholly considered by professionals. Therefore, ethical sensitivity should be improved by engaging multidisciplinary teams in patient care (Gonzalez-de Paz et al., 2014).

Medical Education Ethics

Sasso, Bagnasco, Bianchi, Bressan, and Carnevale (2015) argued that nursing students and nurses become morally distressed whenever they confront ethical dilemmas

while making decisions during clinical practice. The nursing students and nurses may, therefore, experience professional dissatisfaction which may affect their relationships with their colleagues, patients, and patients' relatives. Moral distress among nursing students and nurses is manifested through feeling frustrated, guilt, anger, anxiety, depression, wish to leave the profession, and loss of self-esteem (Sasso et al., 2015; Wojtowicz, Hagen, & Van Daalen-Smith, 2014). Sasso et al. (2015) conducted a systematic literature review study about moral distress in undergraduate nursing students. The main objective of their study was to elaborate the effect of dilemmas and rational, organizational, and environmental factors on moral distress in the nursing students during their professional education and clinical experiences. The study used 157 journal articles published between 2004 and 2014. The articles were screened using the assessment sheet developed by Hawker and colleagues. The review process and data analysis were supervised by an expert specialized in moral distress issues. The main finding after data analysis was that health care disparities, student-mentor relationship, and individual characteristics of the students negatively impact decision-making and nursing care, consequently causing moral distress. Sasso et al. (2015) believed that little is known about moral distress among nursing students. Therefore, future studies need to investigate interventions for moral distress among undergraduate nursing students.

Trust

Trust is an important component in the relationship between physicians and patients, but studies indicate that it has diminished as a result of medical errors (Rocke & Lee, 2013; Lei et al., 2015). As of 2013, most reports showed that physician' ratings with

regards to trust of patients, were minimal compared to veterinarians, pharmacists, and nurses (Rocke & Lee, 2013). The reasons for the phenomenon may be multifaceted, but it increases concern about medical errors and malpractice litigation. The Institute of Medicine (IOM, 1999) reported that preventable medical errors resulted in between 48,000 and 98,000 deaths annually. In order to increase trust of patients in physicians, the practitioners need to start disclosing errors. According to Rocke and Lee (2013), medical students learn about managing complications, rectifying adverse effects, and correcting misdiagnosis during residence training, but are not taught about disclosure of errors to patients and their family. Lack of educating students during residence training about disclosure of errors to patients and their relatives has contributed to the diminished level of trust in physicians. Therefore, the stakeholders in the education system need to include training about medical errors and disclosure in order to foster the relationship between physicians and patients (Rocke & Lee, 2013). Park (2012) reviewed 20 ethical decision-making models with the aim of developing an approach that integrated the various designs to be used by nurses. The integrated model consisted of six stages that support better performance: dentification of the ethical problem, collection of information to develop a solution for the ethical problem, development of options for analysis of the problem, selection of best option and its justification, development of practical ways of implementation ethical actions and decisions, and evaluation of the process and development of interventions to prevent similar occurrences. A pilot study was conducted using the model and participants reported positive experiences such as increase in confidence in their decisions, and satisfaction with having access to a review

process that is comprehensive with regards to ethical aspects in decision-making (Park, 2012).

Breaking Bad News

Truth-telling can be problematic and distressing when the health professional charged with Breaking Bad News (BBN) to a patient possesses insufficient skills to do so (Layat, Hurst, Ummel, Cerutti, & Baroffio, 2014; Ling,Yu, & Guo, 2019). Layat et al. (2014) investigated the long-term impacts of a simulated teaching intervention that is patient based and integrating lessons on communication skills in ethical reflection on ethical attitudes of medical students towards comfort in BBN, perceived competence, and truth-telling. The two-year study involved two cohorts of medical students and began when the participants were in their third year and ended when they were in their fifth year. The study involved analysis of participants' levels of competence and comfort in BBN and their ethical attitudes during their fifth year after the intervention. Layat et al. (2014) found out that the ethical attitudes of the students towards telling the truth remained stable. Students who felt incompetent or uncomfortable also showed improvement in their competence or comfort levels after the intervention. The students that felt competent or comfortable became more aware of the difficulty of the telling the truth, consequently decreasing their level of competence and comfort. According to Layat et al. (2014), in order to effectively maintain ethical attitudes towards telling the truth, develop new skills, and increase awareness about challenges of BBN situation, students need to be confronted with realistic situation and practice of communication skills need to be integrated within ethical reflection.

Oakley (2015) stated that proper medical ethics extensively use empirical research in the determination of how a proposed action-guidance can help or hinder a doctor from meeting the goals of medicine, as well as in the development of a well-grounded moral psychology. The relationship between practice and theory is consistent with Aristotle's methodology in ethics, in which provisional conclusions on eudaimonia are regularly compared with observations on individuals in the communities. According to Oakley (2015), virtue ethics is known for being expressed outwardly, but it is also essential to understand that taking ethical instructions into difficult and complex setting of medical practice can enhance the understanding of advantages and disadvantages the instructions, which would enhance development of reforms in the profession.

Johnson (2016) focused on the history of nursing ethics in Australia. The main objective of authoring the paper was to provide a historical overview of major achievements in the development of mechanisms for operationalizing nursing ethics in Australia. Johnson (2016) took the view that the main achievements in the Australia's history on development of mechanisms for utilization of nursing ethics have not been well documented. Consequently, Australia's contribution in the global discourses about the history of nursing ethics has not been sufficiently documented. Also, important achievements related to operationalization of ethics in nursing have been slow in Australia compared to other countries. However, nursing scholars in Australia have been making advances in the field, thus Australian perception on nursing ethics has been gaining international recognition (Ryan et al., 2018). According to Johnson (2016),

Australia's nursing ethics requires more advancements though significant success in the field has been made.

Gillon (2015) stated that the four prima facie principles which are beneficence, justice, respect for autonomy, and nonmaleficence constitutes the widely accepted basis for good medical ethics. The approach of using the four principles does not require respect of patients' autonomy to be prioritized whenever two or more principles need to be applied concurrently, instead it provides that other approaches of resolving ethical dilemmas can be used collectively. According to Gillon (2015), the value of the approach when properly understood was that it enhanced universalizability through prima facie principles which ensures that all doctors accept and become committed to the same basic moral language and analytic framework.

Demeh and Rosengren (2015) conducted a qualitative descriptive study in Jordan with an aim of describing nursing students' experiences about clinical leadership during their last year of studies. According to Demeh and Rosengren (2015), the practice of nursing is complex because of the several demands from stakeholders, including colleagues, patients, relatives, and managers. Students, therefore, need to be provided with tools that enable them to practice effectively after graduation. The study involved collecting narrative responses of graduating students that had qualified as registered nurses. Content analysis was used in analyzing the collected data. The results indicate that students perceive that clinical leadership enhances safety in being a nurse. Clinical leadership is also perceived as an eye-opener, a tool for bridging gap, and a role model in the preparation process to becoming nurses. Based on the obtained results, Demeh and

Rosengren (2015) concluded that clinical leadership is valuable in bridging the theory and practice gap in nursing education. The skills used in nursing management help in clarifying and simplifying nursing activities, thus facilitating the transition from a nursing student to a practicing nurse. Therefore, the stakeholders in the education sector and health care organizations need to focus on the learning requirements in nursing management in order to enhance development skilled nurses (Connolly, Sweet, & Campbell, 2014; Demeh & Rosengren, 2015).

Chiapponi, Dimitriadis, Özgül, Siebeck, and Siebeck (2016) assessed the impact of an interdisciplinary teach-the-teacher program on ethical issues in health care education for physicians. Chiapponi et al. (2016) had taught the course to 97 physicians from various countries in Asia, Europe, and Africa. After the course, the physician completed a self-assessment questionnaire about interest and competence in the ethical issues in medical education. The sessions on ethical issues in medical education involved participants working in groups to identify, evaluate, and discuss ethical dilemmas in essays written by medical students. A large group experience was also conducted to explore the four main orientations of the participants in critical thinking: relativism, consequentialism, absolutism, and internationalism. Chiapponi et al. (2016) found a self-perceived increase in participants' ability to recognize and explain students' dilemmas and ethical issues, participants' knowledge about teaching professionalism and students' dilemmas and ethical issues, and in participants' ability to describe both behaviors of teachers and students, and students' perspectives. Additionally, participants' feeling of comprehending their own learned patterns of differentiating right from wrong increased

after completing the course. The four contrasting main ethical orientations did not show significant differences with regards to participants' gender, nationality, or age. Chiapponi et al. (2016) said that ethics in education is important for medical teachers. The self-perceived competence for teachers can be increased through working in small groups on case vignettes.

Bureaucratic Ethics: Commitment to the Group

Nurse leaders control the largest portion of workforce in clinical settings, therefore, they have influence in establishing sustainable practice improvement through ensuring activities of nurses are aligned to the objectives of their institutions (Ortega, 2018; Phillips, MacKusick, & Whichello, 2018; Riklikiene, Karosas, & Kaseliene, 2018; Seekles et al., 2016). For instance, nurse leaders can institute Moral Case Deliberation (MCD) programs, which support clinical ethics in handling moral issues (Seekles et al., 2016). Also, best practices cause patient satisfaction with service provided as a result of the influence of the nurse leaders (Barkhordari-Sharifabad, Ashktorab, & Atashzadeh-Shoorideh, 2018; Ozaras & Abaan, 2018; Seekles et al., 2016). For instance, people with dementia prefer to live at home if nurses appreciate their values and autonomy (Long, 2019; Schwartz, 2018; Sellevold, Egede-Nissen, Jakobsen, & Sørlie, 2019; Smebye et al., 2016).

Ethical decision-making is affected by gender, generational factors, level of education, and length of employment (Dierckx de Casterle et al., 1997; O'Connell, 2015; Silva, 2018). Males are stricter in ethical decision-making compared to female (Craft, 2013). Both education level and specialization have impact on decision-making, because

nurses have been found to be more ethical in decision-making compared to other practitioners in the medical profession (Gonzalez-de Paz et al. (2014) Increase in education level also causes increase in desire to acquire informed consent among service recipients (Douglas & Butler, 2012). Practitioners that practiced for many years are more experienced, therefore, are effective in making ethical decisions compared to nurses that are newly employed (Heidari & Ebrahimi, 2016).

Aliakbari, Hammad, Bahrami, and Aein (2014) conducted a descriptive study involving 35 Iranian nurses with experience in health care delivery in a hospital or outside-hospital context after a disaster. Aliakbari et al. (2014) were of the view that nurses encounter unfamiliar and new legal and ethical challenges that may not be common in their daily practice, after a disaster situation. The objective of their study was to explore the experience of Iranian nurses regarding disaster response and their views on expertise needed by nurses during the disasters. The results of the study included five themes as areas which nurses need to be competent in order to work effectively during disaster. One of the themes that emerged pertained to the legal and ethical issues that accrue during response to disaster. The theme involves two subthemes of professional ethics entails nurses' professional responsibility and sense of ethical duty and adherence to law relates with nurses' observation and familiarity with legal requirements. Aliakbari et al. (2014) contributed information that may be useful in developing a program for preparing health care professionals to work effectively in disaster settings.

Coe and Fulton (2016) stated that nurses and policy directives have differing opinions about the elements of care. A lot of research has been conducted about the

concepts of care and caring, but the influence of the discourse has not been investigated. In addition, a few studies related to social constructionism have been conducted, but only few have used Foucaultian-influenced analysis in identifying the existing discourses and the influence in social situations of care and caring. Coe and Fulton (2016) involved investigation into discursive causes of the existing discourse and demonstrates how the influence of power related with discourses of social arenas have impacted nursing practice. The study's findings were developed based on grounded theory and utilizing situational analysis. Twenty-two one-on-one interviews were completed with by community-based practitioners. Analysis of the interviews showed social construction of 4 distinct arenas. Also, the analysis indicated that nursing care in each arena differed. Each constructed social area contained associated discourses that aligned to it. The research further evealed that conflict, the negotiation that occurs, and the process of negotiation and conflict that influence differing views of nurses (Coe & Fulton, 2016).

Wright, Zammuto, and Liesch (2017) stated that specialization in disciplines cause challenges in maintaining macro-level values of the discipline during practice by the professionals at the micro level in organizations. Wright et al. (2017) conducted a qualitative study involving physicians in the emergency-department and their interactions with specialists from other professions in the hospital. Wright et al. (2017) investigated preservation of professional values by specialists through two institutional work procedures in which moral emotions that are linked to other people's interests play an important role. In the first process, a perceived episodic challenge arises due to value conflicts during interactions with professionals from different specialties, eliciting

transitory moral emotions which stimulate institutional maintenance work through actions of individuals. In the second process, a perceived systemic challenge occurs due conflict between organizational practices and professional values, eliciting moral emotions which are shared by all specialists. The emotions cause all people to participate in institutional maintenance work, which changes the practice of an organization. According to Wright et al. (2017), by focusing on values as the cause of conflicts and the motive for professional action in organizations, their model enhances the understanding of everyday work of specialists.

Group Influence on Ethics

Solvoll, Hall, and Brinchmann (2015) stated that healthcare providers offering care to learning-disabled individuals encounter challenges in differentiating right from wrong. The health care providers need to be aware about their expectations with regards to ethical values while assisting individuals with learning disability. Solvoll et al. (2015) investigated the ethical challenges faced by health care providers assisting learning disabled adults. The setting of the study was a community institution and it involved two focus groups, each consisting of six healthcare providers. Data were collected through taping the conversations during the focus groups. The taped conversations were then transcribed to verbatim. Analysis revealed themes includingd the dilemma in making appropriate decision that requires conflicting actions, being a spokesperson for the client, searching for someone to share the responsibility, and health care providers expecting fixed solutions immediately. The results indicated that providers wanted to be advocates for the clients. In addition, the health care providers felt obliged to be the spokespeople

for the clients, but they also needed someone to share the responsibility with. Also, group discussions caused the providers to expect immediate fixed solutions to the problems. Solvoll et al. (2015) concluded that healthcare providers encounter demanding ethical challenges while helping adults with learning disability. The main problem is that independent providers do not feel secure while making decisions that involve contradictory actions. The conversations about ethical problems faced by the providers do not offer immediate solutions, but the visualization of the challenges is an indication of their need for support (Solvoll et al., 2015).

De Wilde, Ten Velden, and De Dreu (2017) argued that groups make effective decisions compared to individual decision makers when the members in the team open-mindedly contribute and evaluate their own and their fellow team members' insights and information, and when they constructively discuss criticisms and doubts. However, making decisions through groups is also affected by nonconformity and need to collaborate with others, and self-censorship (Kim, Kim, & Park, 2016). Consequently, members of the team may refrain from sharing their information, which impacts the potential of groups in making effective decisions. Little information is known about neurobiological factors that initiate group decision-making and information sharing, compared to its socio-motivational antecedents (De Wilde et al., 2017). Therefore, De Wilde et al. (2017) sought to investigate the influence of neuropeptide oxytocin in enhancing group decision-making and information sharing. Oxytocin has been hypothesized to increase socialization by shifting a person's focus from self-interests to group-interests. Additionally, oxytocin has also been found to enhance interpersonal

coordination in social dilemma situations and increases communication between partners (De Wilde et al., 2017). De Wilde et al. (2017) was a double-blind placebo controlled experiment involving groups of 3 people performing hidden profile tasks. The study found no evidence about conformity induced by oxytocin. The placebo groups that received oxytocin showed focus on important information and repeated it more often. The findings indicated that oxytocin had the potential of initiating group decision-making processes. Therefore, oxytocin can be used in making ethical decisions during dilemma situations in clinical settings (de Wilde et al., 2017).

Shared decision-making is an ethical practice, but its full implementation in the clinical setting requires more effective approaches (Elwyn, Frosch, & Kobrin, 2015). Most studies that have evaluated shared decision-making in groups have focused on its short-term implications such as affective or cognitive consequences on patients. The aim of Elwyn et al. (2015) was to hypothesize long-term implications of a wider set of implications of shared decision-making at organizational, team, and interactional levels. According to Elwyn et al. (2015), from the perspective of a clinician, shared decision-making process can be viewed as either impractical and burdensome or protective and intrinsically rewarding. Shared decision-making at group or interactional levels results in development of a culture of collaboration and deliberation that are guided by principles. At the organizational level, shared decision-making enhances patient experience, and results in fewer legal challenges and complaints. In the long term, group decisions lead to changes in utilization of resources, reduction of costs, and modification of the composition of workforce, among others. According to Elwyn et al. (2015), shared

decision-making through groups in clinical setting enables practitioners to continuously remember the ethical need for respecting patient autonomy.

Cai et al. (2016) stated that most patients in the Neuroscience Intensive Care Unit (NICU) lacked the capacity to decide on treatments by themselves. As a result, surrogate decision makers need to make preferences about treatments decisions on behalf of the patients, oftentimes in challenging circumstances in which prognosis is uncertain, thus requiring the intervention of a neurointensivist. Cai et al. (2016) reviewed literature on the process of determining preferences of NICU patients through collaboration of the surrogate decision makers and physicians. Cai et al. (2016) suggested that situations in the NICU setting in which surrogates are required to decide on behalf of the patient require meetings between the physician and the family of the patient. Shared decision-making process through meetings improves family and patient outcomes and minimizes conflicts. Through the meetings, the physicians share their medical knowledge about the treatment that the patient should be offered and the family provides views about the preferences and values of their patient. Therefore, the meetings enhance mutual sharing of expertise and information which results in providing care and medical treatments that is appropriate and preferred by the patient (Cai et al., 2016).

Ethical Competence

Proper understanding of moral distress among nurses in critical care requires an explorative qualitative approach in assessing their views (Au et al., 2018; Choe, Kang, & Park, 2015). Choe et al. (2015) used Giorgi's phenomenological research approach to investigate moral distress experienced by Korean critical care nurses. The study involved

purposive sampling using 14 nurses in critical care and data was collected through face-to-face interviews. The results included five themes of conflicts with the policy of the institution, disagreements with physicians, dilemmas caused by limited autonomy of the nurses regarding treatment, suffering caused by lack of ethical sensitivity of staff toward patients, and preference of work over care and treatment. According to Choe et al. (2015), the shortages of staff members are aggravated by increased turnover of personnel leads to ethical conflicts due to pressure to care for a greater number of patients. Consequently, reduction in number of staff members results in increased ethical conflicts and reduced patient satisfaction.

Goethals, Gastmans, and Dierckx de Casterle (2010) noted that the healthcare system placed great emphasis on the ability of nurses to exercise medical–technical competence while delivering care . Yet Goethals et al. (2010) reported that many nurses described difficulty with the ethical dimension of care in practice. They were not authorized to make choices about patient care in accordance with their own values. They reported moral conflicts about the way that they delivered care, resulting in a negative impact on nurse morale and the quality of care that they provided to patients.

Goethals et al. (2010) described nurses' ethical choices as the product of a complex process of reasoning, decision making, and implementation in practice. The process involved cognition that was influenced by personal and contextual factors, including the need to perform in a challenging work environment. Nurse are frequently compelled to accommodate decisions made by others that are above them in the hierarchy

of authority in the medical environment, and the result is less individually adapted care (Goethals et al., 2010).

Fernandes and Moreira also aimed at understanding nurses' reasons for considering situations as ethical issues, and the intervention measures required. The settings were polyvalent ICUs in four Portuguese hospitals. Participants were selected through homogenization of different samples. Qualitative content analysis was used in data analysis. The results showed that decisions regarding end-of-life, interaction, privacy, health care access, and team work were ethical issues. Also, institutional, team, and personal aspects emerged as the reasons for nurses experiencing the ethical issues. According to Fernandes and Moreira (2012), team and personal resources need to be used in solving ethical issues, and training and moral development are the most suitable strategies that should be used.

Lind, Lorem, Nortvedt, and Hevroy (2012) conducted a qualitative study to investigate experiences of relatives of patients in intensive care units regarding nurses' duties and relationship with them during the process of decision-making in end of life involving 27 relatives of 12 patients that had died. The relatives were interviewed about their perceptions on the challenging ethical situations. The results of are that regardless of bedside experiences of compassion, comfort, and care, nurses were viewed as evasive and vague in their communication, and relatives did not have a long-term perception in the dialogue. In addition, a few relatives were of the view that nurses were involved in meetings with them and doctors. Lind et al. (2012) argued that the ethical consequences of lack of engagement in communication by nurses results in increase in uncertainty and

loneliness. Lack of engagement through communication also contributes to increased experience of relatives in feeling responsible for obtaining information and comprehending their role during decision-making process. Therefore, ethics in clinical practice during decision-making process in end-of-life requires that nurses should increase their involvement in order to increase the satisfaction of the relatives (Lind et al., 2012; Satake & Arao, 2019).

Nursing Leadership

The initial institutionalization of evidence-based practice improvements in nursing, with the recognition of leadership as an essential element, is influenced by several factors. However, limited knowledge is known about persistent change, including the influence of nursing leaders on continuity of practice improvements over a long period of time. Fleiszer, Semenic, Richie, Richer, and Denis (2015) conducted a qualitative descriptive case study that included 39 interviews, document reviews, and observations in order to describe the influence of actions by nursing unit leaders on the sustainability of the Best Practice Guidelines (BPG) program on inpatient units. Fleiszer et al. (2015) found that the levels of BPG sustainability were higher in units which formal leadership teams used integrated set of activities and strategies. The important strategies involved reinforcing expectations and monitoring priorities. The activities which include discussion, integrating, and evaluating, among others, enhanced the sustainability of BPG practices among the staff members. Sustainability of BPG practices was also enhanced through fostering learning and exchange and leadership processes. As a result, sustainable BPG practices promoted accountability and teamwork. Fleiszer et al. (2015)

indicated that unit leaders needed to strategically orchestrate synergetic and overlapping efforts in order to attain long-term continuity of BPG practice improvements. The efforts are important to unit leaders because they may influence sustainable practice improvement through aligning activities and strategies to their institutions' objectives (Fleiszer et al., 2015).

Seekles, Widdershoven, Robben, van Dalfsen, and Molewijk (2016) conducted an exploitative pilot study to investigate the approach of handling moral issues at Dutch Health Inspectorate (IGZ), the evaluation of Moral Case Deliberation (MCD) as ethics in clinical support, and the future perceived needs and future preferences regarding support for clinical ethics while handling moral issues at the IGZ. Seekles et al. (2016) indicated that MCD is implemented in educational programs and health care institutions as an approach to support clinical ethics. Employees in regulatory institutions frequently encounter moral challenges, yet no previous research related to the utilization of clinical ethics in health care regulations had been conducted. The study by Seekles et al. (2016), therefore, described and assessed MCD use in IGZ. Data collection involved interviewing MCD participants in the focus groups and interviewing 6 stakeholders in IGZ. The findings of showed that professionals rarely recognized moral problems; employees reported the need for structured and regular moral support in regulation of health care; MCD meetings were evaluated positively; the most important MCD outcomes were learning from others and feeling secure; and more support was needed for successful MCD implementation at IGZ. The respondents perceived deliberation of moral case as an

important form of support for clinical ethics in handling moral issues in regulation of health care (Seekles et al., 2015).

Smebye, Kirkevold, and Engedal (2016) stated that the care for dementia patients at home is challenging, and it associated with the ethical dilemma of balancing patients' autonomy with their well-being and safety. The design for Smebye et al. (2016) was qualitative hermeneutic and it is based on nine cases. The aim was to explore the ethical dilemmas related to autonomy that were recognized after dementia patients opted to live at home. The theoretical framework used involved concepts of beneficence, ethics of care, paternalism, non-maleficence, and autonomy. Each of the nine cases consisted of a triad: the professional caregiver, relative caring for the patient, and dementia patient. The inclusion criteria were age older than 67 years, diagnosis of dementia, moderate rating for dementia, ability to communicate verbally, and expressed wish to live at home. The professional caregivers and relatives of patients recorded in the register were also included (Smebye et al., 2016). Data collection involved interviewing professional caregivers and the relatives of the patients. Additionally, field notes were recorded after observation interactions between professional caregivers and persons with dementia during activities at the center. Ethical dilemmas related to autonomy were identified through deductive analysis. The interpretation of the results was based on the perspectives in the theoretical framework. Analysis of the collected data revealed three ethical dilemmas: Autonomy of the dementia patient when conflicted with autonomy of the patient's relative, beneficence of the professional caregiver and the patient's relative, and the professional caregiver's and the relative's need to protect patient from harm.

Smebye et al. (2016) stated that in order for people with dementia to remain living at home, they relied on the acceptance of other people to appreciate their autonomy and live based on their identified values. Also, paternalism can be justified in the perspective of non-maleficence and beneficence toward patients.

Influence of Gender on Ethical Decision-Making

Lehnert, Park, and Singh (2015) focused their literature review study on business ethics and state that a lot of research has been conducted on the factors, influences, and conditions in the process of ethical decision-making. The review synthesized information from 141 articles and synthesized the information in order to establish the trend of four ethical decision-making categories which include: behavior, intention, judgment, and awareness. The results revealed gender with regards to decision-making as among the most researched areas of study. Females are reported to be more ethical in decision-making compared to males, but males have been found to be more consistent in decision-making compared to females. However, most studies indicate that gender does not have influence on decision-making. Lehnert et al. (2015) also noted that gender has gained consistent attention of researchers, and more studies are focusing on boundary conditions in which gender influences and does not influence the process of ethical decision-making. A few studies are focused on the direct implications of gender.

Craft (2013) performed a review of studies on ethical decision-making conducted between 2004 and 2011. Eighty-four articles were reviewed, resulting in 357 findings. The individual findings were categorized based on application into organizational variables, the moral intensity concept, or individual variables. The four-step model for

ethical decision-making by Rest (1986) was used in summarizing the findings using dependent variables including judgment, behavior, intent, and awareness. The results indicate that gender is frequently reported in findings related to research on ethical decision-making. Most of the research reported on gender-specific variables that have potential effect on ethical decision-making. According to Craft (2013), men were found to be stricter in ethical decision-making process compared to women. However, the women's intention to act ethically was also found to be dependent on the context. Women depended on both utilitarianism and justice while making ethical decisions, while men relied on justice only, and their decisions were more universal than contextual. Craft's assertion (2013) that females were more ethical than men in decision-making is consistent with results of Lehnert et al. (2015). Craft (2013) also found that men required more training on ethics compared to women. Additionally, men were more likely to mislead their competitors compared to women.

Though some studies are related to gender of people offering the services such as (Craft (2013) and Lehnert et al. (2015), the research conducted by Lathrop, Cheney, and Hayman (2014) focused on the influence of the patients' gender on ethical decision-making. Lathrop et al. (2014) opined that many surgical procedures do not require detailed processes, for instance a patient arriving at the Emergency Department (ED) suffering from severe abdominal pain as a result of appendicitis is immediately operated after a few hours once informed consent is obtained. However, a few situations are not straightforward such as cases involving infants and pediatric patients. The decisions related to surgical procedures on the infants and elderly patients require the health care

community to be prepared sufficiently to guide relatives in making the right choice (Ball et al., 2018). Lathrop et al. (2014) stated that the Making Ethical Decisions about Surgical Intervention (MEDSI) tool has been designed to provide guidance to health care professionals, families, and patients that need to make ethically charged decisions about interventions requiring surgery for pediatric patients. The MEDSI tool is based on the principles of non-maleficence, patient autonomy, and beneficence and it is meant to promote respect for the patient's religious and cultural preferences, compassion, follow-up in a clinical setting, and truth-telling. The tool is also used in conducting a surgical procedure on an intersex infant. The tool contains a stage in which the parents need to make a decision after consultation with the health care providers in order for them to provide informed consent about the sex that they prefer their child to remain with (Lathrop et al., 2014).

Also, Anderson (2015) focused on the process involved in decision-making while assisting infants with Disorders of Sexual Orientation (DSD). Infants the DSD conditions are not able to make their decision, therefore, their parents can provide informed consent on their behalf. However, Anderson (2015) opined that the infants' autonomy in decision-making is not respected after the parents have provided informed consent. Besides autonomy, health care providers while assisting the infants' parents in caring for infants with DSD need to consider other moral principles of non-maleficence and beneficence. Consequently, parents and health care providers may find it morally right to delay surgical alteration of ambiguous genitalia of infants until they become of age to make informed consent about the gender they prefer (Anderson, 2015).

Influence of Education Level on Ethical Decision-Making

Douglas and Butler (2012) conducted a qualitative study with aim of reviewing literature related to ethical decision-making process in the health care industry. Literature that was published after the establishment of the Code of Ethics in 1995 by the Joint commission on Accreditation of health care organizations was reviewed and evaluated. Concept and preliminary indicative content analyses were conducted to identify themes and subthemes that emerged. According to Douglas and Butler (2012), in medicine, increase in education and specialization impacts practitioners' decision, thus nurses have been found to be more ethical in decision-making, compared to health care administrators and physicians. Because moral reasoning is an important concept in ethical behavior and decision-making, practitioners should be obligated to practice it (Schwartz, 2016). Moral reasoning can be enhanced by incorporating the medical ethical reasoning model (MER) into the medical curricula. The MER model was developed with the intention of resolving ethical conflicts in the medical field. The model first assesses practitioner's medical knowledge base, personal biases and attitudes, and cognitive reasoning approach. The next stage involves cognitive skills that help in ethical dilemma situations. The skills comprise of a four-step process of identification of problem, making a decision, planning, and taking an action (Douglas & Butler, 2012).

Payne and Farrell (2015) stated that interprofessional (IP) education has become a means of enhancing the overall quality of health care and a way of improving practitioner's understanding of their roles. However, procedures that address IP role interactions are not clear in cases when conflict and tension emerge in circumstances of

moral uncertainly. Payne and Farrell's (2015) research was exploratory in design involving reporting of secondary analysis results from studies that relate to moral distress and IP ethics collaborations and consultations. Eleven IP participants from five disciplines were used. An IP role model was constructed from themes that emerged in order to identify district actions and barriers that comprise IP interactions that enhance ethical decision-making in the clinical context. Payne and Farrell (2015) concluded that particular role boundaries of professions recognized uncertainty as participants interacted with different health care roles in clinical dilemmas (Payne & Farrell, 2015).

Casali and Day (2015) stated that healthcare managers including doctors, non-clinically trained professionals, allied health care practitioners, and nurses, among others, encounter a raft of variables in the process of making a decision in their workplaces. The health care managers rely on personal experiences, personal factors, organizational factors, and individual ethical philosophies in decision-making in situations that lack clear protocols. Therefore, understanding the main approaches to ethical decision-making process by clinically trained health care managers is important in increasing awareness about the significance of ethical decision-making among managers (Casali & Day, 2015).

Casali and Day (2015) conducted a cross-sectional study with the objective of understanding the differences in styles of managerial ethical decision-making processes among Australian health care managers. The exploratory study utilized the Managerial Ethical Profiles (MEP) scale. The study adopted a taxonomic approach which simultaneously considers different ethical factors that have potential influence on managerial ethical decision-making. The factors were put into clusters then analyzed to

identify different patterns of ethical decision-making among managers. Casali and Day (2015) found the following five managerial ethical profiles across both non-clinically and clinically trained health care managers: chameleons, defenders, duty followers, guardian angels, and knights. Also, there was a significant statistical difference between non-clinical and clinical manager types across the five profiles. Casali and Day (2015) were of the view that ethical decision-making profiles are similar in both clinically and non-clinically trained managers.

The World Medical Association Declaration of Lisbon regarding patients' rights outlined important constituents of informed consent. For instance, patients have the right to self-determination, mentally competent adults have the right to withhold or give consent to any therapeutic or diagnostic procedure and have the right to be provided with necessary information to make their decisions. The informed consent doctrine requires physicians to explain to the patient risks of an intervention and possible alternatives before embarking on the therapeutic procedure. The information should be provided to the patient in a way that is appropriate to the culture of the patients to ease their understanding (Agu et al., 2014; Axson, Giordano, Hermann, & Ulrich, 2019).

According to Agu et al. (2014), the desire for health care providers to participate in decision-making that requires informed consent is related to the educational status of people involved. Agu et al. (2014) aimed to assess the influence of educational level of community members and their attitudes towards informed consent practice. An interviewer- and self-administered questionnaires was used to obtain responses of

consenting adults. The setting of the study was three randomly sampled communities in Enugu State located south-east of Nigeria.

Agu et al. (2014) found that least 70% of the participants irrespective of their education level would not allow all decisions regarding their health to be made by their physician. A small proportion of the respondents with informal education (18.5%) were willing to leave the whole decision-making process to the doctors compared to 21.9% of the respondents who had tertiary education. With regards to being informed about all that can go wrong with an intervention, 61.5% of respondents with informal education considered the doctor incompetent and unsafe while 64.2% with tertiary education had confidence in the doctors (Agu et al., 2014). At least 85% of respondents with tertiary education preferred the doctor who would conduct the procedure to obtain consent compared to 33.8% of participants with informal education. About 70% of the respondents with tertiary education stated that informed consent was important in procedures that involve children, while 64.4% of those with primary education and 76.4% of those with formal education did not recommend informed consent for the procedures (Agu et al., 2014).

Patient inability to comprehend information in informed consent documents was the most frequent response from participants with informal education regarding why they would let the doctor to make all the decisions. According to Agu et al. (2014), the study is helpful to health care providers in the process of obtaining informed consent. The study showed that knowledge about informed consent increased with increase in educational

status, however most respondents irrespective of their level of education would want to participate in decisions regarding their health (Agu et al., 2014).

Jafree, Zakar, Fischer, and Zakar (2015) were of the view that clinical settings were places where hidden knowledge is acquired by medical professionals during practice and training. Hidden knowledge refers to the undocumented part of education in medicine that dictates professional processes and practices through continuous socio-cultural forces (Jafree et al., 2015). The medical trainers, licensed practitioners, and instructors have influence on the future of ethical practices of colleagues and medical students through hidden curriculum. The safety of patients is dependent on nurses' training and ethics in the profession. Because nurses are front-line practitioners that spend most of their time with patients, they have considerable knowledge about hidden curriculum and ethical practices in the clinical setting. According to Jafree et al. (2015), the health care sector of Pakistan is affected by exclusion of ethical lessons from nursing and medical education curricula and lack of monitoring ethical violations that occurred in clinical settings. The objective of Jafree et al. (2015) was to identify the aspects of hidden curriculum that encourage ethical violation in a clinical setting during practice and clinical training through nurses' real-life experiences. The design for the study was qualitative involving four focus groups discussions and 20 interviews. It used a sample of nurses in order to identify their clinical experiences with regards to violation of ethics. Content analysis was utilized to identify subcategories of violations of ethics, as experienced by nurses, within four categories of code of ethics in nursing of patient

informed consent; professional integrity and guidelines; co-worker coordination for patient safety, learning, and competency; and patient rights.

Some of the subcategories of ethical violations included: non-reportage of errors and blame-shifting, a culture of non-learning, and withdrawal of nurses from providing particular treatment because of fearing for their safety (Jafree et al., 2015). The other subcategories of ethical violation included: patient discrimination based on their socio-demographic status, absence of taking patients' informed consent by nursing students, near-absence of taking consent from patients in most of the non-surgical interventions, reluctance by patients to be treated by nurses, nursing students being exploited and assigned tasks of staff members, and nurses facing frequent violence in clinical setting. According to Jafree et al. (2015), urgent and immediate intervention involving collaborative efforts by ethics regulatory organizations, the health care sector, and the government is needed in order to minimize ethical violations in the medical field. In addition, public awareness on reporting of ethical violations by providers, perceptions of the public of nurse identity, and socio-cultural value changes in health care organization were needed (Jafree et al., 2015).

Influence of Generational Factors Among Nurses on Ethical Decision-making

Workplaces including clinical settings consist of young employees, mid-career employees, and older employees. Different generations in workplaces consist of Millennials (born between 1982 and 1999), Generation X (born between 1965 and 1981), Baby Boomers (born between 1946 and 1964), and Traditionalists (born between 1925 and 1945) (Schullery, 2013). Millennials are the youngest individuals to enter the

workforce, Generation X employees are in their mid-careers, and Baby Boomers and Traditionalists are older employees. A generation consists of individuals born in a particular range of birth years. The individuals in a generational cohort have shared the same experiences which influence their values and characteristics in workplaces (Fishman, 2016). For instance, Jamieson, Kirk, Wright, and Andrew (2015) investigated the factors influencing retention of nurses in Generation Y found that hygiene-maintenance issues are considered dissatisfiers by younger nurses that could influence their wish to seek employment in cleaner health care centers. Jamieson et al. (2015) used a descriptive exploratory design in a study utilizing a national wide online survey in New Zealand, which produced both qualitative and quantitative data. The sample constituted of 358 registered nurses in Generation Y and their views about career, work, and nursing were collected.

Jiménez-López, Roales-Nieto, Seco, and Preciado (2016) used an exploratory comparative study using a cross-sectional survey method to investigate the personal values of nursing professionals and nursing students. According to Jiménez-López et al. (2016), prior research on personal values of nursing professionals and nursing students involved investigation into personal values among nurses, but none had assessed whether the predictions made by intergenerational value change theory are true with regards to various generations of nursing students and professionals. The theory forecasts a shift in personal values of nurses in younger generations towards self-expression as of greater importance than professional responsibil8ty. Therefore, besides investigating the personal values held by nurses, Jiménez-López, et al. (2016) also aimed at determining whether

profiles of generational value were aligned to the predications of intergenerational value change theory. The sample population consisted of 2295 nursing students and 589 nurses who were recruited from 10 primary care centers and four public hospitals in Spain. The method of data collection was an open survey. The collected data was categorized into groups based on the value lexicon construction approach and analyzed using contingency tables with standardized residuals and Pearson's $\chi 2$. The results indicated that the importance of professional and ethical values decreased among the younger nurses and nursing students, and other values related to personal well-being and social relationships increased among the younger nurses and nursing students (Jiménez-López, et al., 2016).

Winterich, Morales, and Mittal (2015) investigated the influence of sadness, happiness, and disgust on regulating the degree of consequences of a person's judgments of another individual's ethical behavior. Though Winterich et al. (2015) was focused on the relationship between emotions and ethical behavior, it is connected to the influences of generational factors on ethical decision-making in the clinical setting. The results indicated that both happiness and disgust are associated with heuristic-based processing, therefore, result in more reliance on the degree of consequences when ethical judgments are formed. Neural emotions and sadness are associated with systematic processing, and therefore lead to less reliance on the degree of consequences. According to Winterich et al. (2015), the magnitude of consequences on judgments of behaviors that are unethical is more when individuals that make decisions are experiencing happiness and disgust verses neutral state or sadness. In addition, ethical severity is dependent on factors at individual level, especially the current emotional state that is expressed by a person, acting together

with the magnitude of consequences to influence ethical decisions-making process. Practitioners that are dissatisfied may express their disappointment through disruptive behaviors such as incivility, bullying, and horizontal and lateral violence. The consequence of unethical behavior results in medical errors, poor patient satisfaction, increased cost of care, and low turnout of employees, among others (Lachman, 2014; Tarım, Zaim, & Torun, 2014). According to Schullery (2013), the younger generations are more likely to demonstrate dissatisfaction in a workplace because of their high expectations with regards to salary and working conditions, compared to older individuals.

Winterich et al. (2015) were consistent with Lalonde and Hall (2017), who investigated the relationships between characteristics of preceptors such as emotional intelligence, cognitive intelligence, and personality, and outcomes of socialization by new graduates such as job satisfaction, turnover intent, and role conflict, during a preceptor-ship program. The study involved a multi-site and cross-sectional design and purposeful sampling. Dyads of new nurses and preceptors were recruited after a preceptor-ship program and a Pearson's correlational analysis was utilized in examining the relationships. The sample used consisted of 44 new graduate nurses and 41 preceptors. The results indicated that preceptor personality personalities of conscientiousness, emotional stability, and openness were associated with new graduate nurses that reported more turnover intent, role conflict, ambiguity, and job dissatisfaction (Lalonde & Hall, 2017).

Length of Employment Influence on Decision-Making

Level of nurses' experience is correlated with their length of employment. Nurses that have been practicing for many years have more experience in the field compared to those that have are newly employed. Therefore, nurses that have been practicing for a long time are also efficient in making ethical decisions in the clinical setting because of their increased experience. Benner's theory from novice to expert (1982) is applicable in explaining the influence of nurses' length of employment on ethical decision-making. According to Benner (1982), the novice stage is the first level of experience. Nurses in this category are new graduates with no practicing experience. The rule-governed behavior of the novices is inflexible and limited, and they rely on texts and leaders in making decisions. Students pursuing their undergraduate studies in nursing can be categorized as newly employed in the novice stage, because they take part in practicals that expose them to little experience in the field (Baptiste & Shaefer, 2015). Therefore, student nurses require more skills and experience to enable them practice efficiently. For instance, Heidari and Ebrahimi (2016) stated that nursing students lack decision-making ability and critical thinking skills that are important in medical emergency and other clinical matters. The nursing students can acquire and develop decision-making ability and critical thinking skills through theoretical and clinical training. Heidari and Ebrahimi (2016) aimed at examining the relationship between the ability to critically think and skills in decision-making of emergency medicine students. The study utilized an analytical and descriptive design and 86 medical emergency students in Shahrekord, Iran constituted the sample. The California Critical Thinking Skills Test (CCTST), a

researcher-made questionnaire for decision-making, and a demographic information questionnaire were used in collecting data. Analysis of data was conducted using SPSS software using Pearson's correlation coefficient and analytical and descriptive statistical tests. The results of the study indicated that the average score for skills in decision-making was 8.66 ± 1.89 and the score for critical thinking was 8.32 ± 2.03, showing a statistical relationship between the decision-making score and critical thinking score (Heidari & Ebrahimi, 2016).

According to Benner (1982), the second stage of experience is the advanced beginner. Nurses in the advanced beginner stage demonstrate standard performance in decision-making because they have acquired prior experience in real situations that have enabled them to identify important components of the process. Additionally, advanced beginners develop principles that are based on their experiences which they utilize in guiding their actions (Maltese, Svetina, & Harsh, 2015). The third stage of experience is related with nurses that are competent. Nurses in the competent stage have been practicing for about three years, therefore, have gained experience from planning actions based on their conscience, which enables them to achieve more efficiency in ethical decision-making. Nurses in the fourth level of experience are proficient, that are able to perceive and comprehend situations as whole parts, and their holistic understanding enhances decision-making (Maltese et al., 2015). Proficient nurses also learn from experiences about what to expect in particular situations and how to adjust plans. The nurses in the fifth stage are experts in the field. Expert nurses no longer rely on principles in making decisions because of their extensive background experienced. Expert nurses

also rely on their intuition in decision-making and are flexible and proficient (Robert, Tilley, & Petersen, 2014). Expert nurses have acquired advanced experience in the field and are recruited as nurse managers, among other leadership roles in health care organizations. The nurse managers are relied for effective decisions and are resourceful in influencing other nurses toward positive change.

Van Bogaert et al. (2015) appropriately demonstrates that experienced nurses are efficient in clinical activities including decision-making. Van Bogaert et al. (2015) conducted a qualitative phenomenological study with the objective of investigating nurse manager's experiences and perceptions about structural empowerment of staff nurses and its impact on the style and role of nurse manager leadership. According to Van Bogaert et al. (2015), nurse managers' leadership duties may be perceived as challenging because of the involvement of staff nurses in both organizational and clinical decision-making processes and the complex requirements of patients. Van Bogaert et al. (2015) examined nurse managers' leadership between December 2013 and June 2014 in a Belgian university hospital involving a sample of 8 medical nurse managers at a time when the nurse management style was being converted from a flat interdisciplinary design to a classical hierarchical departmental model during the time of the study (Van Bogaert et al., 2015). The results indicated that nurse managers were familiar with structural empowerment of nurses in the institution and had positive attitudes toward it. The nurse managers confirmed that empowerment of staff nurses had a positive impact on the nurses' work performance in the areas of critical reflection, autonomy, and responsibility.

Staff nurses reported that empowerment also enhanced their own communication skills which improved patient safety and quality of care (Van Bogaert et al., 2015).

Summary and Conclusions

The literature review supported the importance of nurse ethics for better patient health outcomes. Nurse administrators and nurse educators, and policy makers should focus on moral reasoning and ethical decision-making based on principlism theory that contains four principles which include beneficence, autonomy, non-maleficence and autonomy. In developing moral ethics that can help in guiding practice, the clinical ethicists should consult with other stakeholders then consider features of good moral ethics which include coherent, informed, reasonable, illuminating, and consistent.

Moral ethics should be taught in medical schools using more advanced approaches that complement ethics of daily practice which may assist in intervening challenges that are encountered in medical schools and health care institutions such as toleration of unprofessional and unethical behaviors. Good ethical practices in clinical settings require that practitioners in different professionals should continuously consult each other because various individuals have different opinions about situations leading to dilemmas. In addition, the advances in medical practices with time necessitate consultations among professionals from different specialties. The reviewed literature indicates that the curriculum of medical education influences the moral reasoning and decision-making among nurses during practice. For instance, lack of fostering of students' communication skills affects their ability to tell the thought whenever they need to break bad news. Therefore, reforms which require integration of important skills

during practice are needed in the medical program in order to enhance graduation of competent nurses.

Nurses from various backgrounds adhere to specific legal requirements and have differing perceptions of ethical duty. As a result, nurses respond differently to disaster situations. Models that consider values as the cause of differing actions of nurses need to be developed to enhance the understanding of everyday work of the practitioners. The reviewed studies indicated that groups make more effective decisions compared to individuals. Ethical decision-making with regard to group influence requires that practitioners consult with patients and their families before choosing a treatment option. The advantage of group decision-making is that it increases ethical competence, satisfaction of patients and their relatives, and reduces turnover of practitioners.

The studies reviewed were conducted in a variety of countries. For instance, 13 studies were conducted in the US, 16 in Europe, three in Australia, and two in Canada, among other countries. A number of methodologies were used for the studies, with 43 using qualitative methodology, five quantitative, and one mixed method. Sixteen studies used phenomenological research design, 23 were broad exploration and descriptive, two were systematic literature reviews, while the remaining two involved a case study and grounded theory. Interviews were the most widely used method of data collection, in 12 studies. Questionnaires were used in seven of the studies, and one utilized a combination of methods including focus groups and interviews. The method of data collection was not indicated in most studies that involved broad exploration and descriptive research design.

Chapter 3: Research Method

The purpose of this nonexperimental quantitative correlational study was to identify the factors that influence ethical decision-making processes for nurses working in federal healthcare facilities in the United States. The sample population was recruited via social media and were not required to disclose which federal health facility employed them. The study involved a correlational research design to examine the extent to which the control variables of training in personal ethics during professional training, professional experiences, and personal experiences affected the dependent variable of ethical decision-making as shown through EBT scores among 381 nurses working in federal healthcare facilities in the United States.

This chapter will cover the study design and rationale and methodology, including the population, instrumentation, procedures, validity, statistical analysis, and ethical considerations of the study. The chapter includes a detailed presentation of data collection processes and statistical analysis findings based on linear regression. This chapter also presents tables and graphs that are used to display and interpret data.

Setting

The study was conducted completely online. There was no brick-and-mortar setting. Participants were recruited online via invitations issued on LinkedIn and Instagram (see Appendix B) and the participants completed surveys online.

Research Design and Rationale

Variables

The dependent variable for the study was ethical decision making by 381 nurses working in federal health care facilities in the United States which was measured by the nurses' ER scores on the EBT. ER refers to personal standards based on personal values which nurses consult to make decisions when facing dilemmas or decisions about patient care. Ethical behavior refers to actions that nurses take based on ER (Dierckx de Casterle et al., 1997). ER was calculated based on the ranking of the dilemmas based on importance. In the project, the three control variables were personal experiences, professional experiences, and professional training on personal ethics. The influence of control variables on the dependent variable was measured using the EBT survey instrument.

Research Design

The study involved a quantitative correlational approach because this design facilitates objective data analysis. A correlational study design was selected to determine whether or not there was a correlation between the four variables. Data collection was conducted using the EBT questionnaire. The aim of the correlational research was to determine to what extent a relationship existed between ethical decision making and personal and professional experiences and professional training in personal ethics. Nursing practice involves ethical decision-making which often results in choices about care that lead to suboptimal patient health outcomes. Disruption of ethical decision-making processes for nurses is a major issue since it can affect patients' well-being and

influence quality of care (Barlem & Ramos, 2015). Nurses can feel pressured to violate nursing ethics by making choices about patient care that benefit the healthcare facility for the sake of efficiency and cost-effectiveness but which leader to a lower quality of care for patients. Violation of nursing ethics can lower the quality of life in federal healthcare facilities and for nursing practice in general.

There are no specific time or resource constraints for the design choice, since a survey method is inherently brief, involving minimal costs. The study was nonexperimental, involving a survey of nurses' behavior and perceptions of the real world. Though variables can be manipulated using an experimental design to understand causes of certain clinical decisions, the researcher did not choose an experimental study design because it would not serve the purpose of the study which was to investigate nurse ethics.

This study involved use of the EBT survey to collect data from nurses working in federal healthcare facilities. The survey method has various limitations and benefits. The primary benefit of using questionnaires to collect data is that they are simple, straightforward, and cost-effective (Creswell, 2013). However, surveys can also involve collection of inaccurate data if one or more survey items are unclear or inappropriately designed. Inappropriately-constructed items can also cause high nonresponse rates, thus affecting the validity of surveys (Johnson & Wislar, 2012; Peytchev, 2013). Structured questionnaires are less time intensive in relation to coding and analysis compared to qualitative methods such as interviews (Creswell, 2013). Finally, the use of questionnaires facilitates the collection of relevant data that can be used for future

research, contributing to an improved understanding of nurses' ethical decision-making processes and also facilitating the establishment of interventions and policies that can improve quality of care.

Methodology

Population

The target population for the study consisted of all nurses working in federal healthcare facilities. The sampling frame consisted of 381 nurses who responded to an invitation to participate (see Appendix B) that was posted on LinkedIn and Instagram. They self-reported as meeting the criteria for the study and agreed to participate.

Prospective participants were recruited through the invitation to participate (see Appendix B) which informed them that they must be currently employed in a federal healthcare facility as a nurse delivering direct care to patients and not in an administrative role. Specifically, participants needed to have professional status as a licensed nurse (RN, LPPN, or NP), ability to read and write in English, be employed as a nurse in a federal healthcare facility, not receive care as a patient in the facility where they were employed, be employed as a direct provider of patient care, willing to sign an informed consent form, and willing to complete the online survey. Respondents self-reported as meeting the criteria for the study and agreed to participate.

Sampling and Sampling Procedures

Participants were selected using a convenience sampling technique, where subjects are chosen based on their characteristics as well as convenience. Recruitment of participants was done by posting an invitation to participate in the study (see Appendix

B) on LinkedIn and Instagram. In addition to being time-saving, convenience sampling allows the investigator to collect primary data and trends about a given topic without the complications that are associated with randomized samples (Riva et al., 2014). The primary advantages of using a convenience sample include cost-effectiveness and the ability to gather data that would otherwise be impossible using probability sampling (Creswell, 2014). In addition, convenience samples involve minimal time to collect data and can be used to document specific qualities or phenomena that occur within a given sample (Riva et al., 2014). However, convenience sampling is limited by lack of representativeness and risk of sampling bias (Creswell, 2013). Due to lack of representativeness of the sample, findings from studies that use convenience sampling cannot be generalized to an entire population.

Inclusion criteria. All study participants were required to be nurses who worked at a federal healthcare facility, but did not receive care as a patient there. Participants were required to be credentialed as one of the three major types of degreed nurses: RN, LPN, or NP. Participants in the study were required to possess an active license to practice nursing. Participants had to be directly involved in providing patient care, not receiving care in the facility where they were employed, and not serving in an administrative role.

Exclusion criteria. Participants were not recipients of care at the facility where they were employed at the time of the study in order to avoid conflicting experiences of being a patient as well as a caregiver. Nurses employed in in management or

administrative or management positions were excluded from the study because they were not directly involved in delivering care.

Recruitment. Recruitment of participants in the study was conducted through posting an invitation on LinkedIn and Instagram. Nurses working in federal health care facilities were able to respond to the invitation by clicking on a link that was embedded into the invitation (see Appendix B).

According to Creswell (2005), population size is not important, except when the sample size is greater than a few percentage points of the target population. The target population of all nurses working in health care facilities in the United States is larger than the sample population for this study. Power analysis was used to determine an appropriate sample size. Based on power analysis, the minimum sample size for the study participants, would have been 169 based on 95% power, $\alpha = 0.05$, and medium effect size (0.15).

Sample-Size Analysis

The target population included nurses working in federal health care facilities in the United States. The recruitment process started with calculating a suitable sample size for the study. A minimum of 400 nurses working in federal health care facilities were invited to participate in the study and this determined the sampling procedures. Before collecting data, it is essential to research how to determine the correct population size for the study. A small sample size of 30 or less would be inappropriate and would not be a valid representation of the population of interest (Creswell, 2005). Similarly, extremely large sample sizes may lead to resource waste and could expose more respondents than

necessary to research-related risks (Faber & Fonseca, 2014). Thus, it is critical to conduct population size analysis to determine an appropriate sample size. Creswell (2005) provided recommendations for the number of study participants in relation to variables in correlational studies. Creswell (2005) recommended at least 30 participants for correlational studies. For the study, the four variables were Nurse's ethical decisions as shown on the EBT, nurses' professional experience, personal experience, and professional training in personal ethics. Yet the sample size threshold based on power analysis (180) had to be increased to account for attrition of surveys that might be left incomplete. So, the sample size was increased by 25% (45 additional nurses were recruited) to offset incomplete surveys (Salkind, 2003). Based on the number of responses, at least 500 nurses viewed the invitation and considered participating in the survey. Out of the estimated 500, approximately 218± were required; 381 nurses responded and completed the survey.

Procedures for Recruitment, Participation, and Data Collection

The researcher sought authorization from the Institutional Review Board (IRB) prior to starting to recruit (IRB Approval # 04-30-19-0470963). Once permission was granted, the researcher issued an online invitation on LinkedIn and Instagram to potential respondents to participate in the study. The invitation included a brief description of the nature, purpose and objectives of the study, and the instruments that would be used for the survey. The initial response to the survey was more than the researcher had expected and the recruitment period was extended for an additional five weeks. The final number of nurse participants was 381.

Participation

To be included in the study, the participants had to self-report as nurses who were directly involved in care delivery at federal health care facilities in the United States. Nurses employed in administrative or management roles were excluded because they were not involved in direct care. The rationale for the inclusion/exclusion criteria was to ensure that only licensed nurses who were directly involved in care in federal health care facilities were surveyed. Inclusion and exclusion criteria were presented to the candidates in the form of questions. This ensured that the nurses were able to determine if they were suitable for the study.

An anonymous informed consent question was presented as the first page of the survey. If participants gave consent to participate, they were directed to another set of filter questions that confirm inclusion and exclusion criteria. If those rounds of filter questions were cleared, then participants were routed to the full survey. Then an informed consent form was provided to those who agreed to participate in the study. This form guaranteed the informed consent of the participant.

Instrumentation and Operationalization of Constructs

The study was based on a survey involving structured questions. The survey instrument was the EBT questionnaire by Dierckx de Casterle et al. (1997). Bernadette Dierckx de Casterle (1997), one of the authors of the EBT provided the researcher with written permission to use it for this study (see Appendix A). The EBT was appropriate for the study because it facilitated the collection of primary data relating to nurses' ethical decision-making processes in the context of delivering patient care. The EBT contains

five case scenarios that demonstrate how nurses encounter conflicts relating to care in routine work environments. Only two case scenarios from the EBT were used for this study (see Appendix C). Based on each case scenario, participants were required to respond to four questions that were meant to evaluate their ER, actions, and understanding of the conflicts as if the participant were the nurse involved in the case study (Dierckx de Casterle et al., 2008). Each reason provided by the participants represented stages 2 to 6 of the Kohlberg's (1971) stages of moral development which was borrowed from Piaget's theory of cognitive development (Piaget, 1972).

The Piaget and Kohlberg models both seek to explain the evolution of moral considerations and morality in children (Kohlberg, 1971; Piaget, 1972). The EBT is designed to evaluate nurses' ethical decision-making in nursing practice on a daily basis (Dierckx de Casterle et al., 2008; Lapsley & Carlo, 2014). Dierckx de Casterlé et al. (1998) adapted Kohlberg's concept to include the care perspective of nursing commitment to quality of patient care.

Kohlberg's model mainly focuses on conventional, pre-convention, and post-conventional stages of morality (Kohlberg, 1971; Lapsley & Carlo, 2014). Pre-conventional morality is based on external forces and understanding of what is right and wrong in the context of fear (strict obedience to figures in authority) and the desire for self-aggrandizement. People with pre-conventional morality follow rules without considering whether the rules are sensible or right as adjudged by fairness, justice, or convention (Dierckx de Casterle et al., 2008). The conventional stage of morality involves moral considerations within the context of how specific rules agree with their

knowledge of truth and are beneficial in some relationships and societal situations (Kohlberg, 1971). In addition, an interpersonal relationship factor that mediates a power-derived understanding of morality exists at the conventional level of moral development (Dierckx de Casterle et al., 2008).

The post-conventional level of morality development represents an advanced sense of morality towards situations based on individual beliefs and experiences. People achieve an advanced level of morality after evolving out of interpersonal and societal situations that are insignificant because they value concepts of justice and right and wrong and give little importance to rules on morality as defined by authority figures (Lapsley & Carlo, 2014). As a result, the dynamic in society becomes one of understanding how people make moral and ethical decisions and conclusions based on internal and external factors such as professional, personal, and societal experiences, norms, and expectations (Kohlberg, 1971).

Respondents were instructed to analyze each case and select potential solutions to address the stated ethical conflict. The participants were also required to assign values and rank the five reasons for selecting a particular solution. By ranking their reasons for selecting a specific solution, the participants demonstrated their perceptions about preference for an ethical solution for the conflicts. In addition to assessing the nurses' perceptions about their preferred ethical conflict solution, this study also aimed to assess the extent of preference compared to other possible solutions (Dierckx de Casterle et al., 2008). The participants' responses were coded to reflect whether they selected post-conventional solution as opposed to procedure-based reasons for each preference. The

scores ranged from 5 to 55 points. Higher scores indicated that the participants followed post-conventional (self-directed) ethics rather than conventional or procedural ethical rules (Dierckx de Casterle et al., 2008). The scores were important since they described the process of ethical decision making. The scores provided the outcome for the dependent variable in relation to the control variables.

The research questions that guided this study necessitate the use of Likert-scale items in order to facilitate the collection of nurses' perceptions regarding ethical decision-making. According to Wakita, Ueshima, and Noguchi (2012), ethical decision-making processes are fluid constructs that can be measured effectively using dichotomous items. In addition, Likert-scale questionnaires were used because the researcher sought to collect responses that respected nurses' perceptions regarding complicated matters, which cannot be achieved using binary items (Wakita, Ueshima, & Noguchi, 2012). Dierckx de Casterle et al.'s (1997) EBT was utilized to collect data regarding nurses' behavior during hypothetical medical scenarios. Permission to use the EBT questionnaire to collect data for this study was provided by the author of the study (Appendix A). The statistical relationship between the variables was determined by data analysis of the responses on the EBT questionnaire. This was the measurement of the impact of the control variables on the dependent variable ethical decision-making.

Reliability and Validity

The reliability and validity of the EBT was described in a paper published in 1997 (Dierckx de Casterlé et al., 1997). The authors of the EBT analyzed the reliability and validity of the instrument, reporting on a number of significant indications for the

psychometric properties of the scores for ER and implementation of the instrument. The authors proposed that inconsistencies in the EBT could be attributed to the factors that were named in Kohlberg's theory of ethical development and empirical studies pertaining to Kohlberg's theory (Dierckx de Casterlé et al., 1997; Kohlberg, 1971). This confirmed the reliability of the scores on the EBT. The content validity of the EBT is based on development of the instrument to include a combination of dilemmas, arguments and clinical nursing scenarios that reveal nurses' ethical choices. There was a correspondence between the concept and operationalization of the EBT scenarios. Congruency was evident between the nurses that used the EBT in the context of their patterns of ethical choices and Kohlberg's theoretical assertions about ethical reasoning, showing the construct validity of the instrument (Dierckx de Casterlé, et al., 1997). The authors also published a meta-analysis of nine studies in four countries in which the EBT was used to measure nurses' ethical responses (Dierckx de Casterle, et al., 2008). The findings indicated that most nurses displayed a consistent pattern of conforming to conventions when making ethical choices about patient care, rather than making a choice that supported the best interest of the patient.

Data Analysis Plan

Data analysis software. After collection, the data was exported into electronic files and folders for coding and statistical analysis using the SPSS software current version (IBM.com, 2018). The researcher chose SPSS software because it facilitates complex analysis and is effective for manipulating quantitative data. The organizational process before importing data into the SPSS software involved creation of an Excel

spreadsheet into which the data from the questionnaires was loaded. The spreadsheet included headings corresponding to the variables, such as gender. It involved reproducing headers in numerical form (e.g., G010000, G11000, G200000, etc.) and these were converted to logical names: Response number, Consent, Sex, Age, Years of experience overall, Level of employment. This ensured that the software was able to convert the data in a systematic manner.

Data cleaning and screening procedures. The data was organized into a complete file to allow for comprehensive analysis. All the surveys were cross-checked for completeness. Any survey that was incomplete was excluded from analysis. The number of excluded/incomplete surveys were reported in Chapter 4 of the dissertation and the number count of total respondents included them. The questionnaires were assigned unique identifiers to maintain privacy and avoid breaches of confidentiality of the participant data. The survey data was exported to the most current version of SPSS and coded appropriately to facilitate ordinal linear regression (IBM.com, 2018).

Because the questionnaires included Likert-scale items, coding was performed by assigning numerical values to the participants' responses in ascending order of preference. Statistical analysis was conducted using Excel to rename the data and then import it into SPSS while presentation was performed using tables and graphs to ensure identification of significance, trends, and behavior of the data collected. The graphs also facilitated the identification of potential outliers that could influence the results of the study. In addition, statistical analysis was aimed at identifying and assessing the extent and direction of the correlation between the outcomes of the ethical decision making and

the control variables. The use of histograms and bar charts showed relationships in the data and facilitated the contextualization of the results. Discrepant cases were addressed based on their source.

Statistical Tests

A multiple linear regression model was developed to analyze the relationship between the dependent variable of ethical decision-making as shown on the EBT and the three control variables of professional experiences, professional training in personal ethics and personal experiences among nurses working in federal health care facilities. This is typically used when the aim is to predict the value of a variable based on the value of more than two or more variables. The research questions facilitated a more in-depth understanding of nurses' ethical decision-making and its relationship with their personal experiences, professional training in personal ethics, and professional experiences.

Threats to Validity

The concept of validity for measurement involves how the researchers evaluate what they are intended to measure. According to Creswell and Miller (2013), validity refers to the methodological accuracy of data as opposed to data that is hastily and carelessly collected and analyzed. Valid data facilitates the establishment of reasonable conclusions by ensuring that the survey items are designed to appropriately measure the constructs being studied (Golafshani, 2003). Despite objectivity being central to validity, it is important to understand that subjectivity can also be introduced into quantitative studies because coding and interpretation of data are conducted by human beings (Creswell & Miller, 2013).

Consequently, the researcher should focus on satisfying validity thresholds where one can achieve perfection due to human weaknesses. Based on Golafshani (2003), both quantitative and qualitative studies can be influenced by researchers' perceptions of validity and their assumptions. In addition, validity also affects the ability to collect data that can facilitate the generalizability of results, especially in quantitative research. For instance, in quantitative studies, it makes little sense to collect data from a few points in a large sample where significant conclusions cannot be established. In addition to being time-consuming and costly, the required knowledge cannot be achieved because of the small sample sizes. Though generalizability is not the sole focus of validity, it is an important aspect. In the study, validity was achieved by using a standard EBT that has been evaluated for reliability and trustworthiness. In this quantitative correlational study, validity entailed whether the researcher could draw useful and meaningful inferences from the scores of the EBT survey.

Threats to External Validity

External validity refers to the researcher's ability to generalize the findings of a study to a broader population (Creswell, 2013). Specifically, external validity involves how well the collected data represents the larger population to which the findings of a study can be applied and whether the environment and situation are similar to the natural setting that to be generalized (Henderson, Kimmelman, Fergusson, Grimshaw, & Hackam, 2013). Threats to external validity occur when the researcher makes inaccurate inferences regarding the relationship between sample data and different environments, situations, or individuals (Henderson et al., 2013). To minimize threats to external

validity such as representativeness, the researcher only generalized the findings of this study to nurses working in federal health care facilities who were directly involved in care, and the researcher surveyed nurses working in at federal health care facilities in the United States.

Threats to Internal Validity

Internal validity denotes the researcher's control over a study's experimental implementation and their ability to influence extrinsic and intrinsic explanations about the relationship between variables (Creswell & Miller, 2013). Any experiment cannot be interpreted effectively without internal validity (Henderson et al., 2013). Threats to internal validity occur when research activities limit the researcher's ability to make accurate inferences regarding the population from the sample data (Creswell & Miller, 2013). The threats to internal validity in the project include the likelihood of researcher and instrumentation bias. Regression analysis will also help to ensure internal validity and that the data is relevant to the research question.

Threats to Construct Validity

Threats to construct validity arise when a researcher uses insufficient definitions and measurement variables (Holgado-Tello, Chacón-Moscoso, Sanduvete-Chaves, & Pérez-Gil, 2016). Also, threats to statistical conclusion validity occur when researchers make inaccurate inferences because of violations of assumptions (Holgado-Tello et al., 2016). To minimize threats to construct validity, the researcher chose a published survey tool to collect data for the study. To prevent threats to statistical conclusion validity, the researcher tested the assumptions for correlation including linearity, normal distribution,

no or little multicollinearity, no auto-correlation, and homoscedasticity before conducting statistical analysis.

Ethical Procedures

In research activities that involve human subjects, it is important to ensure that all the participants are treated ethically (U.S. Department of Health and Human Services, 1979). In addition, it is critical to protect participants from the possibility of intentional or unintentional harm resulting from a research design or researcher actions. As stated in the Belmont Report, various important principles and guidelines guide the interaction with human subjects when conducting research (U.S. Department of Health and Human Services, 1979). Today, it is the organizations in which the researchers work or study that ensure ethical research, as opposed to the individuals taking part in the study. The study was guided by the guidelines and principles of the Belmont Report which include respect for persons, informed consent, beneficence, information, justice, comprehension, voluntariness, and the systematic assessment, scope, and nature of risks and benefits (Fiske & Hauser, 2014; U.S. Department of Health and Human Services, 1979). The researcher ensured that all ethical guidelines and principles were followed.

Before approving the study, the IRB requested a few adjustments to the recruitment flyer for ethical concerns. After adjusting the flyer to create the final version (see Appendix B), the researcher distributed the flyer and ensured that all the participants signed consent forms before completing the questionnaires. The study setting was also guided by justice and beneficence because the information that the researcher sought from the participants was beneficial for improving patient care through improved ethical

decision-making by nurses. Because the study had various implications and possible unintended consequences for the respondents, the researcher discussed the scope, voluntariness, purpose, risks, and benefits of the research beforehand. The participants were also assured through the consent forms that all the information collected from the questionnaires would be kept confidential and that anonymity would be maintained throughout the study. In addition, the participants were informed that the results section of the study would involve a compilation of information from different data points to eliminate the likelihood of positive identification by third parties (Fiske & Hauser, 2014).

Regarding the maintenance of anonymity and confidentiality of survey data, the researcher conformed to German data protection standards (Schubler & Karniyevich, 2017) involving various steps. First, the researcher used numerical identifiers in the place of names in completed questionnaires. The researcher also used separate Excel spreadsheets for the identifier and demographic information without using names. Also, the researcher was the only person who had access to the datasets. Additionally, all the identifiable data was encrypted to prevent identification by third parties. The IP address for the web-administered questionnaires was also discarded. The researcher assigned passwords to all electronic data and folders where they were stored to prevent unauthorized access. The data will be stored in a password protected computer for five years after the completion of the study.

Summary

The study employed a nonexperimental research design to assess nurses' ethical decision-making processes when faced with dilemmas in practice. A non-experimental

design was chosen because the aim of the study was to identify the existence, extent, and direction of correlations between dependent and control variables. The focus of the study was to address six research questions relating to nurses' ethical decision-making in federal health care facilities. Data analysis was conducted using SPSS. and Excel software. The data collection instrument that was used was de Casterle et al.'s (1997) EBT. The researcher ensured the anonymity and confidentiality of the participants' information as stipulated by research ethics. The researcher also ensured that the participants were protected from possible harm from the research design. For this study, the importance of protecting human subjects related to increasing nurses' motivation and safety and preventing unauthorized supervision and retaliation after the study. The ethical procedures that were followed were critical because the study sought to collect information that could influence policies to enhance nurses' ethical decision-making in practice. Chapter 4 will provide a detailed discussion of the data collection procedures, statistical analysis, and result findings that were used to address the research questions and hypotheses.

Chapter 4: Results

The purpose of the non-experimental quantitative correlational study was to identify the factors that influence ethical decision-making processes of 381 nurses working in unnamed federal healthcare facilities in the United States.

In the study, the researcher addressed three research questions:

RQ1: Do nurses' professional experiences affect their ethical decision-making when working in federal healthcare facilities?

$H_0$1: Nurses' professional experiences do not affect their ethical decision-making when working in federal health care facilities.

H_a1: Nurses' professional experiences do affect their ethical decision-making in federal healthcare facilities.

RQ2: Does professional nurses' training in personal ethics affect their ethical decision-making when working in federal healthcare facilities?

$H_0$2: Professional nurses' training in personal ethics does not affect their ethical decision-making in federal healthcare facilities.

H_a2: Professional nurses' training in personal ethics does affect ethical decision-making in federal healthcare facilities.

RQ3: Do professional nurses' personal experiences affect their ethical decision-making in federal healthcare facilities?

$H_0$3: Professional nurses' personal experiences do not affect their ethical decision-making in federal healthcare facilities.

H_a3: Nurses' personal experiences do affect their ethical decision-making in federal healthcare facilities.

This chapter provides a detailed presentation of data collection processes and statistical analysis findings based on multiple linear regression. This chapter also presents tables and graphs that are used to display and interpret the data.

Data Collection

Data collection was conducted on the Internet, where the questionnaire was administered. Potential study participants were provided with a link to the EBT survey that was displayed in the invitation. Lime Survey software was used to capture data. Respondents were required to complete the informed consent form before accessing links to the EBT questionnaire. The informed consent form contained language informing the respondents that the study was voluntary and they could choose to withdraw at any time. The survey also contained questions relating to inclusion/exclusion criteria, to which participants had to respond correctly to proceed with the survey. They had to self-report that they were licensed to provide care as nurses and were directly involved in providing care, and were not working in a primarily administrative role.

The rationale for using online surveys was that they are cost-effective and time-saving. Online surveys also allow participants to complete surveys at their own convenience and maintain privacy while providing opportunities for honest and accurate feedback, especially when responding to personal questions (Hohwü et al., 2013). Additionally, online surveys are more secure because the researcher can easily set up passwords and encrypted files (Chen & He, 2013). However, online surveys can be

limited by inadequate sampling and respondent availability (Hohwü et al., 2013). For example, some populations may have limited internet access, and thus may find it difficult to complete surveys (Chen & He, 2013). Also, creating a probability sample using web visitations and email addresses is difficult (Hohwü et al., 2013). It was anticipated that the majority of the participants had adequate Internet access.

The data collection technique for the study was a survey using the EBT questionnaire, which was accessed through an online link on the invitation to participate (see Appendix B). The main purpose of using surveys was to collect data from participants, which after analysis resulted in a statistical characterization of the sample. Survey items related to respondents' attitudes, beliefs, behaviors, and characteristics and were collected through mail, personal interviews, telephone, and the Internet. The respondents followed the link provided to access and complete the survey. After collection, data were organized appropriately and exported into electronic files and folders to await coding and statistical analysis using SPSS version 2.0. Data were interpreted using tables and graphs.

Timeframe for Data Collection

Data collection was performed using the EBT survey during May through August 2019. The EBT survey has two case studies showing nurses in daily ethical dilemmas. Participants were asked to answer four multipart questions that accompanied each case study: questions regarding (a) their opinion regarding the most desirable solution to each situation, (b) why or why not to tell the truth, (c) work-related factors for telling the truth, and (d) their opinions about their choices. The four questions helped to evaluate

participants' ethical practices, ethical reasoning, and perceptions regarding nursing dilemmas. Of the proposed solutions to nursing dilemmas (A or B), participants were required to select the most desirable solution, assign a value to the solution, and rank two arguments that led them to select that solution. Each argument characterized one stage of Kohlberg's model (stages 2-6). The ethical reasoning score ranging from 5 to 55 points, was gauged based on participants' preference for postconventional as opposed to preconventional arguments when making ethical decisions. High ethical reasoning scores supported participants' preferences in terms of whether to adhere to ethical principles, self-centered interests, or conventional rules when making clinical decisions.

The third set of questions in the EBT survey (work-related factors for telling the truth) provided four scenarios that challenged participants to implement decisions. The scenarios contained statements that corresponded to stages 1-4 of Kohlberg's model. For every scenario, participants evaluated the probability of implementing their decisions irrespective of situational pressures. The implementation score was computed using the raw scores. The higher the implementation score, the lower the likelihood of participants implementing their decisions in practice.

Discrepancies in Data Collection

Descriptive statistics were computed to provide a comprehensive overview of participants' demographic characteristics. After running data through SPSS, there was no systematic missing data throughout the sample. However, 10-12 variables had missing entries due to non-responses from the participants.

Baseline Descriptive and Demographic Characteristics

Descriptive statistics including frequencies, percentages, and means were used to explain the participants' demographic characteristics. The sample included 381 nurses from healthcare facilities within the United States. Table 1 shows the participants' descriptive statistics.

Table 1

Descriptive Statistics

Variable	Category	*n*	%
Gender	Male	310	81.4%
	Female	71	18.6%
Function in hospital	General nursing	351	92.1%
Nursing Degree	ASN	73	19.2%
	BSN	174	45.7%
	MSN	104	27.3%
Level of Employment	Full-time	270	70.9%
	Part-time	76	19.9%
	Other	5	1.3%
To what degree are ethical issues discussed in team meetings?	Never	45	11.8%
	Regularly	231	60.6%
	Seldom	75	19.7%
Comfort at current work station (Scale of 1-7)	5	39	10.2%
	6	108	28.3%
	7	204	53.5%
Support provided by supervisor (Scale of 1-7)	4	44	11.5%
	5	36	9.4%
	6	86	22.6%
	7	185	48.6%
Support by Policies (Scale of 1-7)	4	31	8.1%
	5	152	39.9%
	6	41	10.8%
	7	127	33.3%
Work Enjoyment (Scale of 1-7)	5	78	20.5%
	7	273	71.7%

Based on the descriptive statistics, the majority of the participants were female (81.4%, *n* = 310), while only 18.6% (*n* = 71) were male. The minimum and maximum ages of the participants were 21 and 65 years old. The average age of the participants was 40.1(*SD* = 12.98). All the participants worked in general nursing. The majority of the participants worked full time (70.9%, *n* = 270), while only 19.9% (*n* = 76) worked part-time. Approximately 60.6% (*n* = 231) of the participants indicated that ethical issues discussed in team meetings regularly, while over half (53.5%, *n* = 204) were very comfortable at their current working station. In addition, 48.6% (*n* = 185) claimed that the supervisors provided them with great support, while one-third (33.3%, *n* = 127) indicated that the support they received from policy is high. Also, the majority of the participants greatly enjoyed working at the hospital.

Results

A multiple regression analysis was used to test if nurses' professional experiences, training on personal ethics, and personal experiences the personality traits significantly predicted participants' ethical decision-making when working in federal health care facilities. Table 2, 3, and 4 provides a summary of the statistics for the regression model between the three control variables of professional experiences, professional training on ethics, and personal experiences and the internal influencing independent variables of gender, age, working environment.

Table 2

Model Summary Statistics

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.734[a]	.539	.531	16.19973

Note. a. Predictors: (Constant), gender, Professional experiences, working environment, Professional training in personal ethics, age, Personal experiences.

Table 3

Model Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	*t*	Sig.
1	(Constant)	-12.327	14.092		-0.875	.382
	Professional training in personal ethics	2.604	1.068	.130	2.437	.015
	Personal experiences	-4.110	.977	-.240	-4.207	.000
	Professional experiences	.647	.133	.210	4.873	.000
	Age	.095	.071	.052	1.335	.183
	working environment	-.744	.480	-.060	-1.551	.122
	Gender	48.619	2.525	.750	19.258	.000

Note. a. Dependent Variable: Ethical Reasoning scores (ER).

Table 4

Analysis of Variance Table

	Model	Sum of Squares	*df*	Mean Square	*F*	Sig.
1	Regression	104891.249	6	17481.875	66.615	.000[b]
	Residual	89751.439	342	262.431		
	Total	194642.688	348			

Note. a. Dependent Variable: Ethical Reasoning scores (ER); b. Predictors: (Constant), gender, professional experiences, working environment, Professional training in personal ethics, age, Personal experiences.

As shown in Table 2, the internal influencing independent variables of age, gender, working environment, and the control variables of professional training in personal ethics, personal experiences, professional experiences, explained 53.9% of the variance (R^2=.539, F (6) = 66.615, p <.0001). The resulting multiple linear regression model was:

ER = -12.33 + 48.619 *Gender* -.744 *Working environment* + 0.95 *Age* + .647 *Professional experiences* – 4.11 *Personal experiences* + 2.604 *Professional training in personal ethics*

As shown in Table 3, Gender ($p < 0.001$), professional experiences ($p < 0.0001$), personal experiences ($p < 0.0001$), and nurses' professional training in personal ethics ($p < 0.015$) significantly predicted ethical behavior independently.

In the project, the researcher addressed three research questions. RQ1 involved the extent to which professional nurses' professional experiences affected their ethical decision-making when working in federal health care facilities. As shown in Table 2, professional nurses' professional experiences significantly affected their ethical decision-making when working in federal health care facilities ($p < 0.0001$). Thus, the null hypothesis that there are no statistically significant effects of professional nurses' professional experiences on their ethical decision-making when working in federal health care facilities, was rejected.

RQ2 addressed the extent to which professional nurses' training on personal ethics affected their ethical decision-making when working in federal health care facilities. Based on the regression model, professional nurses' training on personal ethics significantly affected their ethical decision-making when working in federal health care

facilities ($p < 0.015$). Thus, the null hypothesis that there are no statistically significant effects of professional nurses' training on personal ethics on their ethical decision-making when working in federal health care facilities, was rejected.

RQ3 addressed the extent to which professional nurses' personal experiences affected their ethical decision-making when working in federal health care facilities. As shown in Table 2, professional nurses' personal experiences significantly affected their ethical decision-making when working in federal health care facilities ($p < 0.0001$). Thus, the null hypothesis that there are no statistically significant effects of professional nurses' personal experiences on their ethical decision-making when working in federal health care facilities, was rejected.

Based on Table 4, the multiple linear regression model significantly predicted ethical behavior scores among nurses, *R2=.539, F (6) = 66.615, p <.0001*. Thus, the null hypothesis that there are no relationships between ethical decision-making and professional experiences, professional training on ethics, and personal experiences among nurses working in health care facilities, were rejected.

Summary

This chapter provided a detailed presentation of the data analysis and collection methods that were employed in the current project. The multiple linear regression model yielded a significant relationship between ethical behavior, implementation, and personal experience scores among nurses. However, individually, there was a significant relationship between professional experiences and ethical decision-making among nurses working in health care facilities. The findings also indicated a significant relationship

between professional training on personal ethics and ethical decision-making among nurses working in health care facilities. The results of the project also demonstrated the presence of a significant relationship between personal experiences and ethical decision-making among nurses working in health care facilities. Also, nurses' professional experiences were found to have a significant influence on ethical decision-making among nurses working in health care facilities. Another finding from the project was that professional training significantly influenced personal ethics decision-making among nurses working in health care facilities. Personal experiences were also found to have a significant impact on ethical decision-making among nurses working in health care facilities. Chapter 5 will provide a comprehensive discussion of the results, limitations, implications, and recommendations of the current project.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this nonexperimental quantitative correlational study was to identify the factors that influence ethical decision-making processes for nurses working in federal healthcare facilities in the United States. The sample population for this study was recruited via social media sites LinkedIn and Instagram, and were not required to disclose which federal health care facility they worked in. The study participants were only required to self-disclose that they were employed as a licensed nurse at a federal health care facility. Information about their place of employment was not collected. This project involved a nonexperimental quantitative correlational design to correlate variables that influenced ethical decision-making processes among nurses working in federal health care facilities. Data collection was conducted using the EBT questionnaire, a Likert scale survey involving two out of five ethically challenging scenarios that nurses were likely to experience while providing care. The dependent variable was nurses' ER score, which was calculated by ranking dilemmas on the EBT based on importance. The three control variables were professional experiences, personal experiences, and professional training in personal ethics. The internal influencing independent variables were age, gender, and working environment.

The hypotheses described possible relationships between ethical decision-making and professional experiences, professional training, and personal experiences among nurses working in federal healthcare facilities. Regression analysis indicated that nurses' personal and professional experiences and professional training in personal ethics did not predict ethical behavior significantly. However, the regression model was significant.

Thus, the null hypothesis that there is no relationship between ethical decision-making and professional experiences, professional training, and personal experiences among nurses working in federal healthcare facilities was rejected.

Interpretation of Findings

The findings of this research suggest that personal experiences, professional experiences, and professional training in personal ethics do predict ethical behavior among nurses. The null hypotheses were rejected because p-values were less than 0.05. The results revealed a significant relationship between personal experiences and ethical decision-making among nurses working in federal health care facilities. In addition, professional nurse experiences were found to have a significant influence on ethical decision-making among nurses working in federal health care facilities. Nurse-patient interactions are important because they increase trust. Rocke and Lee (2013) added that healthcare professionals, especially nurses, pharmacists, and veterinarians need higher trust to effectively deliver health care services. Improved trust from patients may increase collaboration and result in positive health outcomes. Laerkner et al. (2015) found that, despite complexity of care, nurses prefer caring for patients who are awake as opposed to those under sedation. Through improved collaboration, patients become comfortable and thus experience positive health outcomes.

Personal experiences were also found to have a significant impact on ethical decision-making among nurses working in federal healthcare facilities. Dwarswaard and Van de Bovenkamp (2015) demonstrated that nurses are faced with three forms of ethical dilemma. The first is whether to promote patients' involvement in clinical decision-

making or respect their autonomy. The second involves reaching optimal health outcomes as opposed to respecting patient autonomy. Finally, nurses are faced with the dilemma of maintaining professional boundaries as opposed to establishing all-inclusive approaches for self-management support. According to Dwarswaard and Van de Bovenkamp (2015), these dilemmas are based on varying perceptions and views regarding the elements of care provision and self-management. Chiapponi et al. (2016) found that nurses' ethical behaviors were influenced by knowledge and perspectives.

The findings indicated a significant relationship between professional experiences and ethical decision-making among nurses working in health care facilities. In addition, the results indicated a significant relationship between professional training on personal ethics and ethical decision-making among nurses working in federal healthcare facilities. Gonzalez-de Paz et al. (2014) indicated that nurses have adequate training and knowledge on ethical norms, and they practice more ethically compared to family physicians and professionals. According to Gonzalez-de Paz et al. (2014), despite paternalistic behavior that health care providers often display toward patients, not all health care professionals provide patient-centered care. Layat et al. (2014) found that nurses' competence levels influenced their ethical attitudes. According to Layat et al. (2014), incompetent nurses or those who are uncomfortable have a reduced ability to make ethical decisions appropriately. Layat et al. (2014) indicated that nurses' ethical attitudes can be enhanced by helping in enhancing their skills and improving their awareness, and allowing them to practice with realistic situations. Goethals et al. (2010) claimed that nurses' medical-technical competence influenced their ability to make ethical decisions. In addition,

Goethals et al. (2010) claimed that nurses were not authorized to make some decisions based on their own values, despite having adequate training. As a result, conflicts that may negatively influence care delivery occur.

The findings of the research were consistent with Beauchamp and Childress' four concepts concerning principlism: beneficence, justice, autonomy, and nonmaleficence. Based on the findings, ethical decision-making among nurses can be influenced by ethical behavior and personal experiences. In all case scenarios, nurses' ethical decision-making was most influenced by the principlism concepts of nonmaleficence and respect for patients' autonomy (Beauchamp & Childress, 2008). Respect for autonomy involves nurses providing patients with information and allowing them to decide whether to receive care, while non-maleficence involves protecting patients from potential harm.

Limitations of the Study

The current research had various limitations that may have influenced the reliability and validity of findings. A primary limitation of the research was the use of convenience sampling, which limited the generalizability of the findings considerably. Thus, the validity of case scenarios in the EBT survey was considerably reduced. Another limitation of the current research was the collection of data once as opposed to longitudinally, which may result in incomplete documentation of nurses' attitudes and opinions regarding ethical decision-making.

Recommendations

Findings of this research suggest that ethical decisions made by nurses working in federal health care facilities can be influenced by their professional and personal

experiences when caring for patients. Further research should focus on additional organizational and patient factors that influence nurses' ethical behaviors to provide more accurate findings. The current researh did not address the influence of moral development on nurses' clinical decision-making. Further studies should also focus on specific factors such as moral development that may affect ethical decision-making among nurses. In addition, evaluation of these factors would contribute in the development of knowledge on nurses' ethical problem-solving. This project also demonstrated that nurses experience various challenges when making ethical decisions. Thus, further research is needed to broaden nursing directors and health policy makers' understanding of the associations between ethical decision-making by nurses behaviors and factors such as age and professional education in ethics.

Findings of this research may have significant implications for nurses, educators, and policymakers in the healthcare sector. Policymakers could apply findings from this research to design policies that promote ethical decision-making for nurses in critical condition that have an impact on patient outcomes and quality of care. This research contributes additional knowledge regarding factors influencing ethical behaviors in clinical practice. Findings may provide nursing leaders with awareness of professional and personal experiences that may influence nurses' ethical decision-making. Thus, healthcare institutions may apply the findings from this research to train nurses regarding concepts related to ethical behaviors, especially nonmaleficence and respect for autonomy.

Implications

Ethical decision-making behaviors by healthcare providers can have significant implications on public health policy, practice, social change, and future research. For example, nurses are required to contribute to the development and implementation of policies involving controversial cases such as rationing of care, abortion, and physician-assisted suicide which are highly regulated in the United States (Kangasniemi et al., 2015). The choices made by nurses can have a significant impact on patients, their peers, health outcomes, quality of care delivered, and the entire health care industry. The findings of the current project reinforced that nurses' ethical decision-making can be influenced by professional experiences, professional training, and personal experiences. The social change implication of this project is the demonstration that ethical behaviors play an important role in clinical decision-making.

Replicating the current project using another approach may provide more reliable evidence on the relationship between nurses' ethical behaviors and their personal and professional experiences. The current project also employed a non-experimental quantitative correlational design to evaluate the factors that influence nurses' ethical decision-making. A qualitative approach involving face-to-face interviews may provide more reliable primary responses on the factors that influence nurses' ethical decision-making.

The findings of this project add to the growing literature on ethical decision-making by nurses. However, the findings did not clearly demonstrate the factors that influence nurses' ethical behaviors in federal healthcare facilities. Thus, additional

empirical evidence is needed on the factors, such as age, daily work environment (routine in nature), and exposure to different levels of nursing emergencies, that influence nurses' ethical decision-making and to what extent.

Conclusion

Nurses' leadership and ability to make ethical-decisions regularly is significantly important in the healthcare sector because of the moral questions associated with advances in medicine and science. For example, some forms of treatment such as genetic testing and organ transplant pose ethical problems that need to be addressed by nurses and other health care professionals. Thus, it is important to promote the awareness of the factors that influence health care professional's ability to make ethical decisions when they encounter these problems. The purpose of this non-experimental quantitative correlational study was to identify the factors that influence ethical decision-making processes by nurses working in federal health care facilities in the United States. The findings indicated that nurses' ethical decision-making was influenced by their professional experiences, personal experiences, and professional training in personal ethics. The project highlights the need for additional training for nurses in ethical decision-making to allow them to effectively apply ethics in clinical practice. Given that nurses encounter different ethical dilemmas on a daily basis, it is important to further strengthen their ability to address these issues competently. A positive outcome that may be achieved by increasing nurses' involvement and ability to address ethical dilemmas appropriately is improved satisfaction, and reduced likelihood of complications. Ethical

decision-making should also be given more emphasis in the nursing curriculum similar to general ethics to improve nurses' background knowledge.

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Appendix A: Permission to Use EBT

Bernadette Dierckx de Casterlé PhD RN
Professor of Nursing Ethics
Academic Centre for Nursing & Midwifery
Department of Public Health & Primary Care
Catholic University Leuven,
Belgium

Cecil D. Blount
Walden University
100 Washington Avenue South
Suite 900
Minneapolis, Minnesota 55401

Re: Ethical Nursing Study and Ethical Behavior Test
October 28, 2016

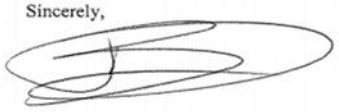
Dear Cecil Dean Blount:

Thank you for your interest in using the Ethical Nursing Study and Ethical Behavior Test (EBT). A copy of both instrument and the necessary scoring keys are attached. It comes with my permission to use them in your work in assessing ethical sensitivity amongst nurses in federal medical facilities.
You can freely use this instrument on the understanding that you will use the instrument only for your research study, send a copy of your completed research study to my attention and provide us with your original research data, so that we can build an international databank about nurses' ethical reasoning.

Enclosed are the requested instruments and scoring keys and additional information that may be of value in your studies.

My best wishes with your important work.

Sincerely,



Prof. Dr. Bernadette Dierckx de Casterlé
Professor Nursing Ethics

Appendix B: Invitation to Participate

Research Participants Needed!

Researcher:
Cecil D. Blount,
Doctoral Student
Walden University

Institutional Review Board (IRB) approval granted on:
04-30-19-0470963

Research Area:
Nursing Ethics

Cecil D. Blount,
Doctoral Student

Survey Link:
http://imt2icore.com/survey/index.php/684616?lang=en

About Your privacy:
This survey is password protected and anonymous. All passwords are generated internally and are randomly selected.

Are you a Nurse?
Consider participating in a study about nursing ethical dilemmas?

What is the study about?
The purpose of this non-experimental quantitative correlational study is to identify the factors that influence the ethical decisions made by nurses working in federal health care facilities in the United States.

Influencing factors:
- How personal experiences become a key element
- How the ethical standards of the medical facility influence the decision making process of nurses.

Who can participate?
Participants in the study must:
- Be a nurse (Registered Nurse, Licensed Nurse, Practical Nurse, Nurse Practitioner, Travel Nurse, ICU RN, Medical-surgical Nurse, Operating room Nurse, Home-health Nurse, Post-anesthesia care unit (PACU) nurse, Staff Nurse, etc..)
- Work in a Federal Health Care Facility
- Provide direct patient care

What's involved?
Participants will be asked to:
- Read two scenarios about choices in nursing care
- Respond to questions about each case study
- **Online survey should not take more than 20 – 25 minutes**

What are the benefits of participating?
Study findings will be used to promote changes in current nursing ethical standards in medical facilities in the United States.

Appendix C: EBT Case Scenarios

Dilemma 1. Mrs. Smith

You are working as a registered nurse on an oncology unit. Mrs. Smith, a 30-year-old patient with leukemia, was admitted to your unit a month ago. After a few days, she had to be completely isolated for medical reasons. She is severely immunosuppressed, and any exposure to infection could be dangerous for her. The doctor has ordered that no one may enter Mrs. Smith's room except her husband, the nurse, and medical or maintenance personnel. These persons must use strict reverse isolation precautions, including careful hand washing, masks, and gloves. You know these precautions and follow them correctly. Mrs. Smith has already been in isolation for three weeks. You have frequently taken care of her during this period, and are again assigned to her today. It is a particularly difficult day for Mrs. Smith. She is raising more and more questions about her future and is worrying about her 10-month-old baby. She feels defeated and doesn't have the courage to keep on fighting. She says she can no longer tolerate being completely separated from her baby. She asked her husband to bring their baby to the hospital this morning. Her husband did so. He is now putting pressure on you to let their baby enter his wife's room. Even though Mrs. Smith knows the risk to her health, she makes it clear to you that it is very important to her to hold her baby in her arms. Mr. Smith assures you that the baby is in good health. The attending physician is not present at the moment and cannot be reached. You know what precautions must be taken in order to let babies or children enter an isolation room. In other words, you have a difficult choice to make -- whether or not to allow Mrs. Smith's baby into the room. THINK CAREFULLY: How would you decide to act in this situation?

Dilemma 2. Mr. Stevens

Mr. Stevens was diagnosed with non-operable lung cancer following a surgical procedure. The prognosis for this 48-year-old patient is very poor. Shortly after the surgery, when Mr. Stevens was not yet completely alert, the surgeon told Mr. Stevens and his wife of the results. It is two days later. Mr. Stevens is continuing to ask questions about his condition. It is quite clear that he either must not have heard or understood the surgeon and thus is not aware of his diagnosis. His wife asks the nursing staff not to tell her husband of the true diagnosis. According to her, this is the best solution considering Mr. Stevens' personality. She tells her husband that a benign tumor had been removed. The physician decides to respect Mrs. Stevens' wish and instructs the nursing staff not to tell Mr. Stevens the true diagnosis.

You work as a nurse in this unit, and you have taken care of Mr. Stevens for several days; you know him fairly well. This patient comes across to you as a very quiet man who knows what he wants and who appreciates his independence. You also know that he trusts you a lot. Today you are assigned to care for Mr. Stevens. You feel that he is scared and concerned. In a conversation with him during his care, he tells you that he has the impression that the true diagnosis is being hidden from him and his wife. Just before you were to leave his room, he asks you, suddenly and quite persistently, to tell him the truth about his diagnosis. He insists on an honest answer. So, you must decide whether or not to tell Mr. Stevens the truth about his diagnosis. What, in your opinion, is the most desirable solution in this situation?