

2015

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Development and Reliability Testing of a Survey

Measuring Trusting and Deference Behaviors in Microethical Nursing Practice

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Novice post-licensure nurses are frequently exposed to microethical nursing practice problems during their first 24 months of formative practice. Often, novice nurses trust the advice of experienced nurse coworkers, deferring to such advice even when they know the advice contradicts evidence-based practice. This study revealed the prevalence of deference behaviors and associated rationale. Study findings emphasize the importance of incorporating conflict management, effective communication techniques, ethical frameworks, and EBP standards within pre- and post-licensure education.

Quarterly publications and meeting minutes from state boards of nursing reveal ongoing and rising rates of disciplinary actions taken against nurses who violate professional standards (e.g., California Board of Registered Nursing, 2013; Oregon State Board of Nursing, 2013; Washington State Department of Health, 2012, as three state nursing boards representing the geographical area of this study). Despite nearly four decades of formal prelicensure ethical education requirements and practice guidelines from professional nursing agencies (American Association of Colleges of Nursing, 2008; American Nurses Association, 2010; International Council of Nurses, 2006; National Student Nurses Association, 2009), some nurses continue to engage in nonprofessional, unethical, and substandard care. Multiple factors contribute to the persistent issue of unethical nursing practice. This study focused on aspects of *trusting and deference* in micro-

ethical clinical situations; that is, *trusting* the advice of perceived expert nurses (staff nurses and preceptors) and *deferring* to such advice (Brighid, 1998; Greenwood, 1993; Krautscheid & Brown, 2014), specifically in situations where the advice may result in compromising ethical standards of practice. Postlicensure novice nurses who experienced *trusting and deference* as students may be habituated to continue these behaviors in their postlicensure practice. This pilot study evaluated a researcher-developed survey designed to examine the prevalence of *trusting and deference* behaviors during microethical clinical practice decisions among novice acute care nurses during their first year of postlicensure practice.

LITERATURE REVIEW

Nursing, allied health, and ethics literature sources were searched using the following key words: *microethics, ethics, novice nurse, trust, defer, moral distress, moral residue, moral courage, moral sensitivity, conflict, organizational culture, professional autonomy, and socialization*. The literature review located resources that confirmed substandard microethical practices among postlicensure nurses. It also revealed factors contributing to the ethical challenges student and novice nurses struggle with when they attempt to consciously use and apply ethical thinking within nursing practice. Missing from the literature was empirical evidence about the prevalence of *trusting and deference* behaviors among novice postlicensure nurses associated with making microethical clinical practice decisions. In addition, no survey instruments were located in the literature that has studied the prevalence of *trusting and deference* behaviors among novice postlicensure nurses.

An operational definition of *microethical nursing practice* is needed to provide context for this research. According to Worthley (1997), microethical decisions are the day-to-day clinical practice situations that nurses routinely encounter. Microethical situations are often not identified as having an ethical component because “the current emphasis on bioethical quandaries tends to obscure the ordinary everyday actions nurses engage in” (Brighid, 1998, p. 1135). Microethical situations reported in the literature include determining whether to leave medications unattended at the

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The authors have disclosed that they have no significant relationship with, or financial interest in, any commercial companies pertaining to this article.

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DOI: 10.1097/NND.0000000000000154

bedside, whether to complete an institutional report when a medication error happens, whether to speak up when sterile technique is compromised, and whether to confront a coworker who does not comply with infection control standards (Berti, Braga, Godoy, Spiri, & Bocchi, 2008; Cameron, Schaffer, & Park, 2001; Cohen & Erickson, 2006; Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004; Mortell, 2012; Murray, 2010; van der Arend & Remmers-van den Hurk, 1999; Worthley, 1997). In contrast, macroethical decisions are associated with bioethical issues; for example, initiating or discontinuing life support or determining which patient should receive a donor organ for transplant. The current authors elected to focus on microethical issues in nursing practice because these issues routinely occur and, as previously noted, are likely to be obscure and can go unnoticed. Patient care outcomes could suffer when nurses do not recognize ethical components embedded within everyday nursing practice situations. The inability to recognize such ethical components also contributes to *trusting and deference* behaviors.

It is also essential to provide operational definitions of *trusting* and *deference*. The word *trust* is generally associated with reliance on the ability, honesty, or truth of someone. In the Krautscheid and Brown (2014) study, the conceptualization of *trusting* was revealed in student nurse text statements that described staff nurses as unquestionably trustworthy safety nets; that is, staff nurses have real-world experience and the students' school of nursing had selected this practice environment for clinical learning. Therefore, the students perceived the staff nurses as a credible resource who would not suggest nursing practice actions that could harm a patient, contradict evidence-based practice (EBP), or cause the student to engage in substandard care. Similar conceptualizations of *trusting* were revealed in Brighid's (1998) study of novice postlicensure nurses. Specifically, novice nurses reported "confusion resulting in a greater reliance on others" (p. 1142), developing "more faith in the opinions of others" (p. 1139), and ultimately *trusting* the advice of coworkers as a coping mechanism to fit in, thus adapting previously held images of professional ethical care to match those of experienced nurses in the work environment. *Trusting*, then, is operationally defined as believing in and relying upon the validity, authority, and abilities of perceived expert nurses. *Trusting* was revealed in the text data of both aforementioned studies, and it was also connected with *deferring* to the advice of perceived expert nurses.

Deference is generally defined as a way of behaving that demonstrates submission and respect toward someone. Senior nursing students reported that, although they knew the staff nurse's advice contradicted EBP, they *deferred* and engaged in substandard microethical practices for the following reasons: They lacked sufficient confidence, they felt powerless to contradict the staff nurse, and they

did not know if the advice was incorrect given the specific clinical context; that is, the students had contextual *naïveté* (Krautscheid & Brown, 2014). Similar conceptualizations of *deference* were noted in Brighid's (1998) study. Novice postlicensure nurses felt vulnerable to social pressures in the workplace, felt powerless to speak up, felt a disconnect between what was taught in school and real-world practice, and described acquiescing to substandard care, thereby "sacrificing their own standards of care" (Brighid, 1998, p. 1137). For this study, the operational definition of *deference* included deciding to act in a manner that submits to the advice of a trusted nurse.

Two qualitative studies were located that explored *trusting* and *deference* experiences during microethical clinical situations among student nurses and novice postlicensure nurses. In a qualitative study of undergraduate baccalaureate senior nursing students, Krautscheid and Brown (2014) reported that, when nursing students were confronted with a microethical clinical decision, they showed a tendency to unquestionably trust and defer to the advice of staff nurses, even when the students knew that the advice contradicted EBP and professional ethical standards. Similar findings were reported among postlicensure novice nurses in a qualitative study by Brighid (1998). Participants in that study reported an inability to speak up against substandard unethical care, not doing treatments the way they were taught because of social pressures, sacrificing standards of care based on coworker advice, and rationalizing the imperfect care as a way of coping with moral distress. Findings in both studies raise critical concerns about repeat exposure to *trusting* and *deference* behaviors and the potential development of moral residue (Webster & Bayliss, 2000). Moral residue increases the risk of becoming desensitized to microethical components of patient care situations. Subsequently, instead of engaging in conscious ethical decision-making, nurses may develop habits of readily *trusting and deferring* to the advice of peers.

According to Brighid (1998), "nurses are more vulnerable to being obedient to authority because of an educational socialization that includes oppressive practices" (p. 1143). Supporting this supposition is an exemplar text segment from a novice postlicensure nurse in Brighid's study: "I think my main concern has changed from caring about the patients, which you would never say in school, to really caring about and helping my buddies" (p. 1140). According to Greenwood (1993), significant discrepancies exist between nursing theory espoused in academic settings and nursing practice role-modeled in clinical learning environments. "Nursing students appear to acquire two inconsistent repertoires of beliefs, values and action tendencies during their professional socialization. The first they acquire from nursing theory, the second from nursing practice" (p. 1472). Both Greenwood and Brighid revealed

educational socialization processes contributing to confusion and conflicting values among student nurses. Confusion within contextually challenging microethical clinical situations is one factor contributing to *trusting and deference* behaviors among nurses.

Both of the aforementioned qualitative studies helped deepen the conceptual understanding of *trusting and deference* behaviors and suggested contributing factors that connect *trusting and deference* with substandard microethical nursing practice. Because both of those studies were qualitative, they had a small number of participants (Krautscheid and Brown sample, $n = 7$; Brighid sample, $n = 22$). Therefore, what remains unknown is the prevalence of *trusting and deference* behaviors among novice postlicensure nurses. Empirical evidence about such prevalence could offer additional evidence by which nurse educators may understand the scope of the problem, helping them to prioritize educational agendas.

Ancillary issues of ethical nursing practice surround the concept of *trusting and deference*, and a comprehensive analysis of all factors contributing to ethical decision-making is beyond the scope of this discussion. Instead, the authors chose to focus on certain aspects of *trusting and deference* within the literature. The literature was rich with primary and secondary sources of evidence that described both student nurse and postlicensure nurse experiences with moral distress, moral courage, moral residue, conflict avoidance, and the interplay between each of these and ethical nursing practice behaviors (Cohen & Erickson, 2006; Corley, 2002; Deshpande, Joseph, & Prasad, 2006; Dierckx de Casterle, Izumi, Godfrey, & Denhaerynck, 2008; Epstein & Delgado, 2010; Miller, 2006). The literature also provided recommendations and rationale for incorporating formal ethical decision-making coursework in undergraduate and continuing education curricula as well as frameworks and suggestions for improving ethical decision-making strategies in clinical practice (Berti et al., 2008; Bicking, 2011; Gropelli, 2010; Kalaitzidis & Schmitz, 2011; Markkula Center for Applied Ethics, 2012; Murray, 2010). Again, focusing specifically on *trusting and deference*, a synthesis of this literature revealed patterns of ethical uncertainty, conformist practices guided by workplace norms, social coercion, conflict avoidance, and the influence that trusted veteran nurses have upon the ethical decision-making processes of both students and novice nurses.

According to Raines (2000), "the profile of the nurse most likely to be involved in an ethically stressful situation was described as hospital based, staff level, young, inexperienced, with minimal formal education, and some ethics course work" (p. 30). In contrast, van der Arend and Remmers-van den Hurk (1999) found no relevant differences "between younger or older nurses, or between novice and experienced nurses. Only a minor significant difference was found between well-educated and less

well-educated nurses and between nurses who completed additional courses and those who did not" (p. 481). Despite the possible distinction regarding which group of postlicensure nurses are most likely to experience microethical decision-making challenges, a consistent finding shows that nurses across the novice-to-expert spectrum (Benner, 2000) experience microethical issues, thus supporting the need for research, including research with a specific focus on novice nurses working in acute care settings. The potential exists for staff-level, novice nurses to *trust and defer* to the advice of perceived superiors. The purpose of this pilot study was to evaluate a researcher-developed survey designed to explore the prevalence of trusting and deference behaviors among postlicensure novice nurses.

METHODS

Procedures

This study used a researcher-developed descriptive cross-sectional survey design. The literature review and a prior qualitative study were used to develop 16 survey items. The original 16-item instrument was reviewed by three PhD-prepared nurse educators, and an item-level content validity index (I-CVI) was calculated for each survey item, which resulted in an I-CVI of 1.00 for each of the items, meeting the I-CVI requirement as stated by Polit, Beck, and Owen (2007). Institutional review board approval was obtained from the authors' academic institution prior to survey administration. The survey's 16 closed-ended questions elicited Likert scale frequency responses ranging from 1 to 7: 1 = *never*, 4 = *sometimes (50% of the time)*, and 7 = *always*. Three survey items (4, 7, and 10) were written in reverse order to reduce response bias (Vagias, 2006). Survey items are presented in Table 2. Internal consistency was calculated for the instrument as a whole. An exploratory factor analysis (EFA) was conducted to search for interdependencies between survey items. Internal consistency and EFA data are reported in the findings section.

Sample

A convenience sampling strategy was used. E-mail addresses of baccalaureate nursing alumni who graduated in August 2011, May 2012, August 2012, May 2013, and August 2013 ($n = 488$) were obtained from the author's school of nursing (SON), a private, faith-based, Commission on Collegiate Nursing Education-accredited undergraduate and graduate nursing program. Internal SON data revealed that 70% of alumni were working in acute care settings; thus, the effective population size was 342 potential participants ($488 \times 70\%$). Participants were included if they had been employed as a registered nurse in an acute care or subacute rehabilitation setting for at least 3 months but not longer than 24 months. Consent to participate was implied by completing and submitting the anonymous electronic survey. The survey results contained no

identifying information that could be connected with study participants, thus ensuring anonymity.

A total of 97 alumni responded to the survey. Eighteen alumni were excluded from participation because they failed to meet inclusion criteria; for example, length of time working and work setting. Six participants were removed from the study because they completed less than 87% of the survey; that is, they did not complete three or more of the survey questions. The final sample size was 73 (21% response rate). Participants were predominantly Caucasian females and in their 20s, and their average length of time working was 9.85 months. Table 1 presents participant demographics.

The SON curriculum provides formal ethics education in a 200-level course as well as formal and nonformal ethics education threaded throughout upper division 300- and 400-level nursing courses with explicit education provided in the following courses: Introduction to Professional Practice, Nursing Theory and Knowing, and Leadership in Professional Nursing. Finally, ethical nursing practice is formally assessed in each clinical learning experience via an explicit learning outcome on the clinical evaluation tool.

The survey was administered electronically via Web-based survey software (Qualtrics). Potential participants were sent an initial invitation as well as two reminder e-mail invitations (at Week 1 and Week 2). Data collection ended 3 weeks after the initial invitation was sent.

FINDINGS

Survey findings are presented in Table 2.

The 16-item pilot survey showed a reliability of $\alpha = .657$. Factor analysis (see Table 3) revealed four factors, and a

Chronbach's alpha was computed for each factor: (a) *deference behaviors* (5 items, $\alpha = .80$); (b) *ethical, evidence-based practice (EEBP) behaviors* (4 items, $\alpha = .78$); (c) *trust behaviors* (4 items, $\alpha = .425$); and (d) *pressure to conform* (3 items, $\alpha = .596$). Factor analysis was used to reduce the number of survey variables, resulting in a nine-item survey with a Chronbach's alpha of .80 for the factors *deference behaviors* and *EEBP behaviors*.

Factor analysis revealed that five of the items reliably measured the prevalence of *deference behaviors* to advice from experienced nurse coworkers that deviated from EBP: Questions 3, 5, 6, 9, and 13 (5 items, $\alpha = .80$). Nurses in the sample reported that when they received advice that they knew deviated from EBP, 30%–50% of the time ($x = 3.62$), they followed such advice because they had faith in the opinion of the experienced nurse. In addition, 10%–30% of the time, they followed such advice because they lacked confidence ($x = 2.93$) and because it was safer to follow the advice to avoid conflict ($x = 2.34$).

Factor analysis also revealed that four items reliably measured *EEBP behaviors*: Questions 8, 11, 12, and 16 (4 items, $\alpha = .78$). Findings revealed that when study participants received advice that deviated from EBP, 70% of the time ($x = 5.13$) they used ethical standards to guide practice decisions and 50% of the time ($x = 4.51$) they looked up policies or researched credible sources. In addition, when study participants did not know best practice standards, 50% of the time their first strategy was to think of ethical standards ($x = 4.84$) and 50% of the time their first strategy was to look up policies or credible sources ($x = 4.39$) to guide their nursing practice.

Factor analysis revealed that four items measured *trusting behaviors* with a low level of reliability (4 items, $\alpha = .42$): Questions 1, 2, 4, and 10. Although the statistics revealed a low level of reliability, these findings contributed to understanding the data as a whole. For example, participants reported that, when they did not know what to do, 70%–90% of the time their first strategy was to ask the advice of an experienced nurse coworker ($x = 5.98$). Participants also reported that 70%–90% of the time they received trustworthy patient care advice from experienced nurse coworkers ($x = 5.83$) and 10% of the time they received untrustworthy advice ($x = 2.47$). Finally, study participants reported witnessing experienced nurse coworkers perform substandard care 10%–30% of the time ($x = 2.87$).

Factor analysis revealed that three items showed a low level of reliability (3 items, $\alpha = .59$) for measuring how often novice nurses experienced *pressure to conform* to advice that deviated from best-practice standards: Questions 7, 14, and 15. Participants reported that 30% of the time they questioned or contradicted untrustworthy advice from experienced nurse coworkers ($x = 3.86$). When participants did question substandard advice, 30% of the time they felt pressured to conform ($x = 3.25$) and 30% of the

TABLE 1 Participant Demographic Data
($n = 73$)

Demographic	Mean (SD)
Months working as a registered nurse	9.85 (4.94)
Age in years	25.01 (4.79)
	<i>n</i> (%)
Gender	Female: 66 (91%)
	Male: 6 (8%)
	Not reported: 1 (1%)
Ethnicity	Caucasian: 63 (86%)
	Asian Pacific Islander: 5 (7%)
	Hispanic: 2 (3%)
	Native American: 1 (1%)
	Not reported: 2 (3%)

TABLE 2 Prevalence of Trusting and Deference Behaviors

Survey Item	Mean (SD)
1. How often do you receive trustworthy patient care advice from experienced nurse coworkers?	5.83 (0.67)
2. When you do not know best-practice standards, how often do you ask the advice of experienced nurse coworkers as your first strategy for deciding what to do?	5.98 (0.96)
3. When you know that the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you defer to the advice because you have faith in their opinion?	3.62 (1.30)
4. How often do you receive untrustworthy patient care advice from experienced nurse coworkers?	2.47 (1.05)
5. When the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you follow such advice?	2.72 (1.25)
6. When you know that the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you defer to their advice because you do not feel confident?	2.93 (1.15)
7. How often do you question or contradict the untrustworthy patient care advice of experienced nurse coworkers?	3.86 (1.39)
8. When you do not know best-practice standards, how often do you look up policies or credible sources as your first strategy for deciding what to do?	4.39 (1.44)
9. When you know that the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you defer to their advice because it is safer to avoid conflict?	2.34 (1.24)
10. How often do you witness experienced nurse coworkers perform substandard care?	2.87 (1.12)
11. When you do not know best practice, how often do you use ethical nursing standards as your first strategy to help you decide what you should do?	4.84 (1.54)
12. When the advice from experienced nurse coworkers deviates from evidence-based practice, how often do you look up policies or research credible sources as your first strategy to help you decide what you should do?	4.51 (1.57)
13. When the advice from experienced nurse coworkers deviates from evidence-based practice, how often do you change your nursing practice to match the practice of experienced nurses?	2.55 (1.19)
14. When you express disagreement or question the advice of an experienced nurse coworker, how often do you feel social pressure to adapt to his or her advice?	3.25 (1.38)
15. When you express disagreement or question the advice of an experienced nurse coworker, how often are you told "This is how things are done in the real world"?	3.16 (1.61)
16. When experienced nurse coworkers' advice deviates from evidence-based practice, how often do you remember to use ethical standards to guide decision making?	5.13 (1.49)

time they were told, "This is how things are done in the real world" ($x = 3.16$).

DISCUSSION, LIMITATIONS, AND RECOMMENDATIONS

This pilot study revealed that the 16-item survey instrument lacked reliability, and four factors were identified within the instrument. Findings from the EFA revealed high levels of reliability for nine items in the survey instrument; that is, five items that loaded with the factor *deference behaviors* and four items that loaded with the factor *EEBP behaviors*. Findings from this pilot study will be used to modify the 16-item survey and conduct a rigorous methodological investigation on the revised survey instrument.

Study findings associated with the nine reliable survey items revealed that novice nurses frequently (70% of the

time) considered ethics and sometimes (50% of the time) considered EBP to guide clinical decisions. These findings are validating, suggesting that educational approaches, in combination with individual attributes, are contributing to ethical, evidence-based nursing practice behaviors. With regard to microethical practice challenges, having faith in the opinion of an experienced nurse coworker, lacking confidence, and wanting to avoid conflict were the most prevalent reasons associated with *deferring* to advice that deviated from EBP. Although participants were practicing nursing under the authority of their own licenses, they continued to lack confidence, felt vulnerable, and deferred to advice of more experienced coworkers. The reported prevalence of *deference behaviors* was low (occasionally to sometimes); however, depending on the specific context of the situation, deferring to advice that deviates from

TABLE 3 Exploratory Factor Analysis Varimax Rotation With Kaiser Normalization

Item	Deference ($\alpha = .80$)	EEBP Behaviors ($\alpha = .78$)	Trust ($\alpha = .425$)	Pressure Conform ($\alpha = .596$)
1. How often do you receive trustworthy patient care advice from experienced nurse coworkers?	.171	.365	.635	-.093
2. When you do not know best-practice standards, how often do you ask the advice of experienced nurse coworkers as your first strategy for deciding what to do?	.240	-.225	.634	-.206
3. When you know that the advice of experienced nurse coworkers deviates evidence-based practice, how often do you defer to the advice because you have faith in their opinion?	.673	-.065	.413	-.131
4. How often do you receive untrustworthy patient care advice from experienced nurse coworkers? (reversed)	-.255	.004	.757	.144
5. When the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you follow such advice?	.839	-.022	.078	.050
6. When you know that the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you defer to their advice because you do not feel confident?	.652	-.283	.155	.158
7. How often do you question or contradict the untrustworthy patient care advice of experienced nurse coworkers? (reversed)	-.180	.159	-.041	.713
8. When you do not know best-practice standards, how often do you look up policies or credible sources as your first strategy for deciding what to do?	.027	.869	-.020	-.151
9. When you know that the advice of experienced nurse coworkers deviates from evidence-based practice, how often do you defer to their advice because it is safer to avoid conflict?	.733	.197	-.089	-.090
10. How often do you witness experienced nurse coworkers perform substandard care?(reversed)	-.606	-.102	.310	-.125
11. When you do not know best practice, how often do you use ethical nursing standards as your first strategy to help you decide what you should do?	.040	.901	-.025	-.023
12. When the advice from experienced nurse coworkers deviates from evidence-based practice, how often do you look up policies or research credible sources as your first strategy to help you decide what you should do?	-.136	.829	.034	.008
13. When the advice from experienced nurse coworkers deviates from evidence-based practice, how often do you change your nursing practice to match the practice of experienced nurses?	.731	-.146	.031	.158
14. When you express disagreement or question the advice of an experienced nurse coworker, how often do you feel social pressure to adapt to his or her advice?	.258	-.307	-.052	.739
15. When you express disagreement or question the advice of an experienced nurse coworker, how often are you told, "This is how things are done in the real world"?	.440	-.165	-.043	.544
16. When experienced nurse coworkers' advice deviates from evidence-based practice, how often do you remember to use ethical standards to guide decision making?	.000	.848	.023	-.125

Note: Factor loadings >.50 are in boldface. EEBP = ethical, evidence-based practice.

EBP could result in harmful consequences for vulnerable patient populations. These findings align with the literature (Carlson, Kotze, & vanRooyen, 2005; Krautscheid & Brown, 2014), emphasizing the importance of intentionally incorporating conflict management, effective communication techniques, ethical frameworks, and EBP standards within pre- and postlicensure education.

An important finding in this study was the reported prevalence of deferring to advice that deviated from EBP to avoid conflict (10%–30% of the time). This finding contributes to other reported findings in the literature. According to Lachman (2014), approximately 31% of novice nurses reported experiencing bullying while at work. Evans (2007) reported nurses experience uncertainty when faced with the dilemma of how to confront an experienced coworker about substandard practices. According to Evans, surveyed nurses stated a fear of retaliation or lack of perceived ability as reasons for why they found it difficult to approach their colleague. Conflict avoidance has a direct link to an increase in the cost of care, a decrease in the quality of care given, increased stress in the work environment, and overall employee dissatisfaction with their jobs (Iglesias & Vallejo, 2012). Nursing professional development educators should be mindful of these possibilities as they establish and monitor optimal learning environments for novice nurses.

This was a pilot study, and thus findings are limited to only the nine items that showed reliability. Additional limitations of the study included a small sample size, a low response rate, a predominantly female population, and all participants being recruited from one site; that is, a faith-based academic institution. In addition, all study participants had a college-level ethics course; thus, the study participants may not be representative of most of the students who graduate from prelicensure nursing programs.

Despite the limitations, this research provided insights into ethical decision-making among novice nurses. When participants deferred to advice that deviated from EBP, the rationale was self-centered; that is, to avoid interpersonal conflict and because they lacked personal confidence. A recommendation for nurse educators is to provide opportunities for active engagement and rehearsal with ethical theories that enhance patient-centered care and deter nurse-centered care. Carol Gilligan's (1982) ethics of care theory provides a good fit for teaching students and novice nurses how to effectively engage in the nurse–patient relationship, encouraging nurses to think beyond the self and emphasizing nursing actions based on caring relationships. According to Gilligan, an ethics of care framework would guide a nurse to consider how one's choices affect the outcomes of a vulnerable individual rather than considering the nurse's personal needs.

An eclectic learning theory approach is recommended to assist nurses in learning how to apply ethics of care in their practice. Transformational learning theory (Mezirow,

2000) in combination with behavioral learning theory (Schunk, 2004; Skinner, 1974) could be used to guide active learning strategies that address long-held attitudes while offering opportunities for intentional rehearsal, repetition, feedback, and critical reflection on actions. These theoretical approaches should help learners think ethically about how their actions or nonactions extend beyond themselves and their coworkers while emphasizing nurse–patient relationships leading toward sound decisions that promote optimal well-being.

Specific recommendations for both academic and hospital-based nurse educators include placing students and novice nurses in high-fidelity simulation environments that are designed to intentionally expose the learner to real-time substandard, microethical nursing practice situations. Simulation would “provide insight and prepare students for incidences of poor professional interactions with the necessary skills to manage these situations” (Flateau-Lux & Gravel, 2013, p. 28). Explicitly teaching microethical decision-making in both didactic and simulation learning environments offers the best opportunity to address all domains of learning: cognitive, psychomotor, affective.

This pilot study revealed that nine items in the 16-item survey instrument showed high levels of reliability. A recommendation for future nursing research is to conduct an in-depth methodological study utilizing rigorous psychometrics to test the nine-item *deference behaviors* and *EEBP behaviors* scale (DeVellis, 2003) with a larger and more diverse sample. Finally, this study found that 30%–50% of the time, novice nurses followed advice that deviated from EBP because the participant had *faith* in the opinion of the expert nurse. A recommendation for future research is to design a qualitative study that would seek to understand the meanings associated with having *faith* in the opinion of nurse coworkers, particularly when the advice is known to deviate from EBP.

Findings from this study offer insights about the prevalence of deference behaviors among novice, postlicensure nurses during microethical clinical practice situations. Deference behaviors could contribute to ongoing issues of substandard practice issues and poor-quality patient care outcomes. Nurse educators are poised to play a vital role in identifying and resolving deference behaviors through educational strategies aimed at helping nurses learn, rehearse, and manage microethical issues in everyday practice.

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