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Micro-Ethical Decision Making Among Baccalaureate Nursing Students: A Qualitative Investigation

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Nursing students frequently are exposed to microethical nursing practice problems during clinical experience. However, little is known about how students intentionally incorporate ethical principles within their decision-making processes at the point of care. The purpose of this qualitative research study was to understand the lived experiences of senior-level baccalaureate nursing (BSN) students confronted with a clinical scenario that required microethical decision making.

Microethics, according to Worthley ([1997]), are the everyday ethical decisions that practicing nurses make within the context of common or routine clinical situations. Conversely, macroethics refers to extraordinary bioethical situations, such as abortion and initiating or withholding life-sustaining treatments. An example of a microethical situation is depicted when nurses are confronted with making contextual decisions that honor best practice, promote patient safety, and respect patient autonomy. For example, what should nurses do when the patient's medications are due, the patient is occupied, and it seems both expedient and perhaps justifiable to leave medications at the bedside with a cognitively aware patient?

When students are exposed to microethical situations, such as the aforementioned medication administration example, they experience confusion, psychological disequilibrium, and moral distress ([Gallagher, 2010]). Callister, Luthy, Thompson, and Memmott ([2009]) said:

Despite exposure to theories of ethics as a didactic part of nursing education, students struggle with its clinical application. This perceived disconnection between ethics theory and clinical practice, as reported by nurses, may be the reason why nurses tend to demonstrate inconsistent patterns of ethical decision making.

(p. 500)

Students at the authors' academic institution have reported experiencing microethical issues and ambivalence between what they have seen role modeled in the clinical setting and what is taught in didactic courses built on evidence-based practice (EBP).

Microethical decision making and EBP work synergistically to promote quality and safety in patient care. As noted by Gallagher ([2010]), the problem may not be that people do not know what *to do* , instead the problem may be that people do not know what they *should do* . Nurses rely on EBP to inform what *to do* . Melnyk, Fineout-Overholt, Stillwell, and Willamson ([2009]) said:

EBP is a problem-solving approach to the delivery of health care that integrates the best evidence from well-designed studies and patient care data, and combines it with patient preferences and values and nurse expertise.

(p. 51)

However, evidence, clinical expertise, and patient preferences do not provide adequate resources to resolve ethical issues. Resolving microethical issues also requires *moral sensitivity* (recognizing an ethical component exists), *moral reckoning* (critical consideration of choices, actions, and consequences), and a commitment to intentionally apply ethical theories (Callister et al., 2009 ; Campbell, 1990 ; Sarvimaki, 1995 ; van Hooft, 2006). The aim of this study was to focus on the ethical component of professional nursing practice decisions.

Literature Review

Nursing, allied health, and ethics literature sources were searched using the following key words: *health care ethics, microethics, nursing education, ethical decision making, learning, teaching,* and *ethical frameworks* . The literature resulted in locating historical and contemporary sources, providing guidance about professional nursing standards and learning theories that could guide ethical decision making. Missing from the literature were rich narratives about students' lived experiences associated with ethics education and incorporating ethical principles during microethical clinical practice decisions.

According to both the American Nurses Association (ANA, 2010) and the International Council of Nurses (ICN, 2012), the goal of ethical action is to protect the health, safety, and rights of the patient. These respective codes of ethics provide guidance to help nurses make ethical and value-based decisions at both the macroethics as well as the microethics level. Microethical issues are discussed frequently in the literature. Students reported that the clinical learning environment is "fraught with conflict and confusion" (Benner, Sutphen, Leonard, & Day, 2010 , p. 169). In nursing practice, expert nurses develop shortcuts that diverge from EBP standards, placing patients at risk for injury. Day and Smith (2007) noted:

These *work arounds* ...lead to increased safety risks. These situations expose nursing students to a well-known dissonance: they learn one way in school, but that is not the way it's done in the *real world* .

(p. 140)

Incidences of ethically charged substandard care were described in the literature (Cagle, 2006 ; Callister et al., 2009 ; Cameron, Schaffer, & Park, 2001 ; Gisondi, Smith-Coggins, Harter, Soltysik, & Yarnold, 2004 ; Mortell, 2012 ; Worthley, 1997) and revealed recurring challenges such as unsafe medication administration, confidentiality breaches, and uneasiness with confronting substandard care and promoting ethical principles. In response, the literature provided recommendations for how to teach ethical decision making.

A review of allied health education literature revealed strategies for teaching professional comportment and ethical formation. Teaching strategies described in the literature primarily incorporated constructivist and transformational learning theory approaches. Constructivist approaches included assisting students to develop ethical comportment through the development of mental models congruent with moral action and hypothetical environmental immersion in ethical decision-making situations via case studies (Benner et al., 2010 ; Gropelli, 2010 ; Sarvimaki, 1995). Transformational learning activities required students to explore converging values, challenge assumptions, and critically reflect on professional practice (Benner et al., 2010 ; Callister et al., 2009 ; Cameron et al., 2001). A noted gap in the literature was empirical evidence about the experiences of BSN students and how they incorporated such ethics education within microethical clinical practice decisions.

Method

This qualitative study explored the experiences of senior-level BSN students who encountered a microethical issue in a simulated clinical environment. Institutional review board approval was obtained. Purposive and snowball sampling strategies were used and considered appropriate for the emergent qualitative design (Creswell, 2009 ; Polit & Beck, 2004). According to Creswell, snowball sampling may be used when existing study participants recruit additional participants from among their peer group. Researchers invited all eligible students to participate. Enrolled participants were then asked to recruit additional study participants. Recruitment ended when thematic saturation was achieved. Senior-level BSN students at the University of Portland were invited via e-mail, and no grade or financial incentives were offered. Anonymity was assured by assigning an identifying number to each participant. Data were collected via one-on-one semistructured interviews, each lasting approximately 65 minutes.

The sample consisted of seven students enrolled in the BSN program at the university. Participant age ranged from 21 to 23 years (average age = 21.4 years). Two participants were men and five were women. Participants were enrolled in their final semester and planned to graduate within 16 weeks. Each participant had successfully completed a three-credit, 200 level ethics course that emphasized major theories in classical and contemporary moral philosophy with an emphasis on understanding and concretely applying theories within macroethical health care situations. Additional

ethics education was threaded within upper division nursing courses (e.g., discussions about the ANA *Code of Ethics* and bioethical case studies), as well as both structured and coincidental clinical exposure to ethical situations. After signing the informed consent form, participants demonstrated clinical decision making in a 15-minute high-fidelity simulation (Lasater, 2007) at the university. The simulation was not recorded, and anonymity was protected. The purpose of the simulation was to replicate an authentic microethical clinical experience. During the simulation, students were expected to administer scheduled medications (antihypertensive and diuretic) to a patient (actor) with a history of heart failure. A staff nurse (actor) was present in the simulation, replicating the authentic clinical learning environment.

During the simulation, medication administration was interrupted when the patient received an important, emotionally sensitive telephone call. The patient was scripted to indicate he or she would like to take the medications later, and the staff nurse was scripted to suggest that leaving medication at the bedside was acceptable practice. In the moment, student participants were confronted with making a microethical decision about safe medication administration, that is, deciding what a nurse should do to positively influence patient care. This scenario was selected specifically because the curriculum ensured repeated exposure to safe medication administration practices, and students had been tested on best-practice principles in the academic classroom and academic simulation laboratory. Immediately following the simulation, participants engaged in a one-on-one semistructured interview using a researcher-developed interview protocol that had been field-tested by three qualitative research experts (**Table**).

Interviews were audiorecorded and transcribed verbatim. Transcript verification occurred by listening to the audiotapes while reading the transcripts. The editing analysis style was used throughout data reduction and data construction. Data were sorted, compared, contrasted, and placed into meaningful thematic categories, resulting in the construction of five central themes. Credibility and dependability were enhanced through member checking. Four of the seven participants responded to the member checking inquiry, indicating the findings fit with their experiences and no modifications were suggested.

Findings

All seven study participants decided to leave the medications on the bedside table for the patient to take at a later, unspecified time. Five central themes related to the experiences of this microethical clinical decision emerged from the data.

Ethics Education: Unapplied and Forgotten

Participants were asked to reflect on educational experiences and describe how they thought they were prepared to incorporate ethical principles within nursing practice decisions. The text data consistently revealed feelings and experiences associated with forgotten ethical education coinciding with an omission of ethical principles. Participants' comments included:

The general ethics class that I took earlier, you can't really count that because that was philosophical ethics. I feel we don't really think about it [nursing practice] in that sort of capacity.

Sometimes it is really easy to just forget about that stuff that you have been taught.

It's there somewhere. It's not as prominent. With ethics, it's like you learn it and you forget it.

These findings reveal real-world experiences of senior-level nursing students who are on the cusp of graduation, licensure, and professional practice. This theme is disquieting as it suggests a failure of the formal curriculum to ensure that students use legitimate ethical principles and intentionally apply these in professional practice.

Despite the inability of participants to recall and deliberately apply ethical principles, language emerged from the text data revealing experiences of ethical formation through the hidden curriculum and nonformal educational experiences (e.g., the influence of observed clinical experiences and the role that an individual's upbringing contributes to moral development). Participants' comments reflecting this included:

Clinical itself has really helped me. Seeing mistakes by other nurses and peers has truly made me more aware of ethical dilemmas.

What prepares me to make ethical decisions in clinical is having those terms brought up in the context where I can understand them.

There's only so much about best practice you can teach in a class. It's not until you've experienced certain situations that kind of helps you.

These exemplar text statements highlight the value of experiential learning in the formation of ethical comportment.

In addition to learning via clinical role models, participants also cited personal upbringing as a significant experience influencing microethical clinical decisions. Participants' comments included:

It's beyond the classroom. I think two people going into nursing school are going to make different ethical decisions, even if they take the same class, based on how they grew up.

A lot of this has to do with my upbringing.

It's [ethics] kind of formed before [students] even get to school. It's like this character that you have.

Interpretation of these findings suggest that clinical experiences and one's upbringing may have a stronger influence on ethical decision making than education provided in formal didactic courses.

Noteworthy here is that none of the participants exhibited deliberate incorporation of ethical principles during the simulation. In fact, each of the participants engaged in substandard care by leaving medications at the bedside, placing the patient's well-being at risk. The findings support the literature (Dohmann, 2009 ; Kalaitzidis & Schmitz, 2012) and suggest a connection between random and nonformal ethical educational and students' inability to make consciously informed decisions.

Preconscious Ethical Thinking

The text data revealed no explicit language directly connecting accepted ethical theories with the decision made in the simulation scenario. Despite the inability to consciously recall and apply ethical theories, the data did reveal connections between participant comments and ethical thinking. In the prior theme, *ethics education: unapplied and forgotten* , one of the student's comments was that "it's there somewhere." This insightful quote highlights the meaning of preconscious thinking, that is, stored memories of ethical principles through a combination of upbringing, education, and experience that are available for recall but lie outside conscious awareness (Epstein, 1994).

Duty Ethics. A duty ethics framework suggests that morality is based on obedience to social norms, prescribed policies, external motivators, and commandments. According to Crowley (1989), the emphasis on ethically right duty serves as a rule book for nurses to protect and justify ethical action in morally complex situations. Duty ethics was exemplified in this study. Participants' comments included:

If there was some kind of punishment for it [leaving the medication at the bedside], it's like, I'd learn from that and not do it again, but if nothing happened, it was, like a good situation.

I don't want any medical problems, I mean, have a patient that gets into medical problems because of something like a law suit or something like that.

So I would feel like I didn't do my job and then I might have to call the doctor and say, "Hey, this guy didn't take them [medications]," and he'd say "Why?" and I'd say, "I left them at the bedside," and I might feel kind of like a fool.

Care Ethics. Carol Gilligan's (1982) *Ethics of Care* theorizes that relationships, not responsibilities, are a core variable influencing ethical decision making. Green (2012) stated, "Human beings do not exist in complete isolation from others. The notion of care is best understood from a perspective that focuses on the associations between people and on the contextual experiences between their relationships" (p. 1). Care ethics text data were found in this study. Participants' statements included:

This is a real person we're dealing with. They're putting their trust in you, in the hospital system, so I feel like it's really important to hold true to that.

Patient autonomy, obviously the patient's wishes, are my first thought. If someone [a patient] is like, "I need to take this call," then it is like, "ok, I'll come back in a couple of minutes to check up on you."

I'd come back after she is off the phone, make sure she's taken her meds, and also check her emotional well-being. This is the most important [thing] right now--you have to find a balance between patient autonomy and safety.

The findings attributed to *preconscious ethical thinking* coincide with *unapplied and forgotten* ethics education. The text data trended toward automatic thinking versus conscious information processing and awareness of ethical principles. According to Epstein (1994), the best hope for explicit application of ethical principles is to make the preconscious conscious. Contextual information processing that occurs automatically, outside of conscious awareness, limits the ability to resolve microethical issues and arrive at informed practice decisions. When students encounter such ethical uncertainty, in the fast-paced and contextual clinical environment, this uncertainty manifests in a variety of ways, such as reliance on staff nurses for advice and guidance.

Trusting and Deference

Participants were asked to reflect on their actions in the simulation and their knowledge of best practice, and then candidly discuss their experiences. Participants reported a fleeting moment of confusion when deciding what the best course of action *should* be. This confusion was quickly resolved by either verbal or nonverbal affirmations from the staff nurse. Participants' comments included:

I kind of gave him [the nurse] a look like, "I'm not really sure if this is right." But he seemed really confident with leaving it [the medication] there. So you know, when my instructor is confident, then, you know, I'm confident.

It kind of helped having the nurse there too, because I would have just kept telling the patient, "No, no" [just take the medication].

Being a student, you listen to your nurse. They've experienced it; they know what they're talking about.

These exemplar statements reflect the whole of the data, bringing out of concealment the meanings attributed to staff nurse recommendations (i.e., being perceived as unquestionably trustworthy).

A preponderance of data revealed that when students are faced with ambiguous microethical decisions, they primarily seek out staff nurse advice rather than contemplating ethical options and potential outcomes, trusting the staff nurses to act as a safety net and intervene in potentially unsafe situations. Students' comments about trusting staff nurses included:

I thought they [staff nurses] were my teacher and that I could trust that they were going to do best and ethical practice. I know it's not best practice to leave medications by the bedside table, but in that situation, I went, "Well, my nurse felt comfortable," so I followed his lead.

They [staff nurses] agreed [to leave medications], so it must be right.

It is really nice to have the nurse there as your lifeline.

These exemplar statements explicitly revealed trusting staff nurses' expertise and implicitly revealed the meaning that students view staff nurses as a safeguard against unsafe, unethical practice. Additional depth to this theme was described by one student's observation that "obviously the nurse is trying to do what is right for the patient and also not put me in jeopardy."

These participants' comments reflect inoperative application of microethical principles within a contextually challenging scenario. According to van Hooft ([2006]), applied ethical issues arise when there is conflict among one's conscience, professional role, and planned actions. Conflict is noted, albeit subtly, in participants' comments that suggested they contemplated the best course of action but ultimately yielded to the advice of the staff nurse and engaged in actions that contradicted best-practice standards. This finding highlights the importance of student-staff nurse relationships,

specifically the influence esteemed superiors have on guiding or misdirecting students' microethical decision making.

A higher view of the text data within the theme of *trusting and deference* suggests that students might be socialized to place higher value on the student-staff nurse relationship than the student-patient relationship. Students who defer to staff nurses and receive positive feedback for this action could be conditioned to repeat this behavior (Skinner, 1974). The implications of this finding (i.e., valuing student-staff nurse relationships over student-patient relationships) could result in what Green (2012) describes as a lack of mutuality in ethical decision making. Students may not only defer to staff nurses, students also may become reliant on nurses to identify situations as having a microethical component. In this way, the development of moral sensitivity with subsequent moral reckoning is stunted, limiting the possibility of arriving at consciously informed, patient-centered clinical decisions.

Reality Testing and Contextual Naivete

Participant comments brought out of concealment the real-life experiences of attempting to blend best practices learned in the classroom and academic laboratory with the realities faced in the clinical setting. Participants shared an understanding that their education could not prepare them for every possible clinical scenario and described attempting to learn how to make decisions in novel and fluid contextual situations. When discussing the practice decision made in the simulation, students' comments included:

It's like, this is how the book says it, but in reality, it's not that cut and dry. Like, you're going to have complications; you're going to have to think on your feet.

You [the academic faculty] can tell us what best practice is and what the hospital policies say, but when it comes down to it, the real-life kind of intersects with that, and what we do in that certain situation comes down to what we've experienced in the past. Best practice is so variable; it varies from nurse to nurse.

Things aren't always going to go exactly as planned or exactly how you learned. You know you are not supposed to leave medication in a room, but...what are the costs and the benefits from it, the pros and cons. Is this really going to get that bad if this goes wrong, and how wrong could it go?

Every situation is different, and every unit has their own like, code of ethics.

These text segments highlight the dissonance that students experience in the clinical learning environment as they struggle to blend academic knowledge within the realities of fluid clinical

practice settings. One factor contributing to the students' experience of reality testing is the valid viewpoint that patient-centered care is contextual (Day & Smith, 2007). As such, the meaning of microethical situations is dependent on the world-view and socially constructed meanings of the involved individuals.

Reality testing in contextual situations is further understood through the meanings associated with inexperience, naivete, and an inability to project potential consequences of action or inaction. The theme, *contextual naivete* , was brought out of concealment in the following student comments:

It really, truly depends on which medication you leave at the bedside whether it's ethical or not. In this sense with Lasix, I mean, the only major common problem that comes is electrolyte imbalance, which therefore has bigger consequences.

I would have liked to see him take the medications quickly. But, I mean, there was no one else in the room. He seemed to be a lot more stable, so it kind of helped me to just... relax and ease back.

Lasix and hydrochlorothiazide are not very dangerous medications. I know meds at the bedside are probably not ideal, but with these ones, especially because she is familiar with them, we determined they are safe to leave with her, that it was OK to leave [the medications] at the bedside.

These participant comments reveal naivete about the potential consequences of leaving medications at the bedside. Specifically, neither medication classifications nor the presence or absence of visitors justifies leaving a medication at the bedside. According to Day and Smith (2007), it is possible that deviations from written procedures, within certain contexts, represent patient-centered care. When a nurse makes a decision to deviate from best practice, the decision should be ethically sound, theory guided, and evidence based. Students who are *contextually naive* may fail to project the harmful consequences of leaving the medication at the bedside. Rationalizations about the situation and how the context justified leaving medications at the bedside are not supported by professional ethical standards.

The data presented in this theme, *reality testing and contextual naivete* , revealed that students struggle in the moment as they attempt to integrate evidence, theory, and ethical considerations within contextual clinical environments. One has to wonder whether the participants possessed adequate *moral sensitivity* to recognize that an ethical dilemma actually existed in this situation (Thiele, Holloway, Murphy, Pendarvis, & Stucky, 1991). When viewed as a whole, the data provide insights about the challenges students experience when making ethically informed decisions. The combined effects of *ethics education: unapplied and forgotten, preconscious ethical action, trusting and deference* to staff nurse

opinions, and confusion associated with *reality testing and contextual naivete* is overwhelming. Each theme contributes to understanding how gaps within the formal curriculum contribute to inoperative ethical decision making.

Moral Disequilibrium: Conflicted and Torn

At the outset of the one-on-one interviews, the participants described their decision to leave the medication at the bedside as supported by the staff nurse and justifiable. However, approximately halfway through the interviews, participants began to describe feeling confused, conflicted, and torn. Although none of the participants specifically stated they had a change of mind about their chosen action, the researchers could sense that they had had time to reflect on the simulation and their nursing practice decision, and they were beginning to doubt whether leaving the medication was the right and ethical thing to do. Participants' comments revealed reflective thinking that occurred after the simulation. Several such comments included:

We go in with all this highly idealistic information and then it gets slowly cut down, changed in a way as we experience more and more things.

Now I'm wondering if even taking the advice from the nurse and leaving those meds was a good idea. It was going to be a busy day, so it's like, yikes, I might not have gotten back here to see if she took that pill and just trusting that she would have.... Leaving the medication on the bedside is something that we're kind of always told not to do.

I've learned never to leave anything [medications] in the room. I felt uncomfortable because that is a big no-no. I was not prepared for how emotionally taxing this is.

Reflection on clinical experiences enables students to identify, face, and reason through intended patient care goals and actual nursing practice. Through reflection, practitioners articulate what worked, what did not work, and potential future actions that will assist them to be more effective (Johns, 1995). Reflection helps individuals improve ethical decision making, provided they "understand what went wrong" (van Hooft, 2006 , p. 24). The findings from this theme highlight the importance of intentionally engaging students in real-world microethical situations with subsequent facilitated reflection to improve ethical decision making.

Discussion and Recommendations

Study findings validate current evidence in the literature and provide new evidence on which to understand how students experience ethical education and make microethical clinical decisions.

Study findings are limited to the experiences of BSN students who were enrolled at a private university and volunteered to participate. Another noteworthy limitation is the average age of participants (21.4 years). Although the average age is reflective of the nursing student population at the authors' academic institution (mean BSN student age = 22.6 years), the findings may not resonate with older students who have more life experiences and maturity. Despite these limitations, the findings provide new evidence that should resonate with nurse educators.

A key finding in this study was the students' experience of formal ethics education (i.e., *preconscious* and *unapplied*) in clinical practice settings. Study findings provided insights about the mismatch between faculty perceptions of student learning via the legitimate curriculum contrasted with the lived experiences of students. According to Doane, Pauly, Brown, and McPherson ([2004]), "Principles of bioethics, moral theory and ethical decision-making are not sufficient to address the multilayered ethical challenges in nursing practice" (p. 250). Benner et al. ([2010]) described a similar viewpoint, "We found a tenacious assumption that the students learn abstract information and then apply that information in practice" (p. 14). Findings from the current study support the literature. Although students have participated in an undergraduate ethics course and engaged in ethical-based discussions in upper division nursing courses, the students' experience is that the educational instruction was forgotten and unapplied in the simulated practice setting. Based on these findings, recommendations for nurse educators include incorporating teaching strategies guided by behavioral learning theory as well as theories and strategies described in the literature review.

Behavioral learning theory concepts help address preconscious and unapplied ethics education. The *law of readiness, law of use,* and *law of disuse* are particularly relevant in this discussion ([Schunk, 2004]). The *law of readiness* theorizes that students will be motivated to learn when they perceive that the information will have direct meaning for a goal they want to achieve ([Knowles, 1980] ; [Merriam, Caffarella, & Baumgartner, 2007]). Therefore, ethics education should be presented in a manner that directly relates to what students need to know to deal with real-life problems. The *laws of use* and *disuse* , as described by Schunk, theorize that repetition, with meaningful connections and timely formative feedback, results in substantial learning. High-fidelity simulation, combined with planned clinical experiences, offers the best possibility to explicitly apply experiential microethics education within the nursing curriculum. An eclectic learning theory approach (constructivism, behaviorism, and transformational) within classrooms, simulations, and clinical environments will help students develop ethical habits, attitudes, and actions to make ethically reasoned clinical decisions. Study participants suggested and were enthusiastic about rehearsing microethical decision making in contextually challenging simulated situations where they could then receive immediate peer and faculty feedback on

performance. A major recommendation for nursing education is to create robust opportunities to learn and rehearse microethical nursing practice.

Another key finding brought out of concealment is the perspective that staff nurses are experienced and trustworthy, and will only deviate from best-practice standards when it is ethically justifiable. One has to wonder if the experience of trusting and deferring to staff nurse recommendations could translate into postlicensure practice and manifest as deference to perceived superiors. This new insight has significant implications in the development of the future nursing workforce. A recommendation for nurse educators is to partner with clinical agencies, providing continuing education programs for staff nurses who teach students. Specific to this study, a suggested continuing education module would include microethical decision making and critical reflection on teaching practices (Brookfield, 1995), explicitly focusing on how one teaches and role models microethical decisions. Through critical reflection and intentional teaching practices, nurses can make their internal thought processes visible and guide students to contemplate and reason through challenging microethical situations rather than limiting student thinking by providing answers. This approach to teaching would generate cognitive disequilibrium and enhance problem solving skills.

Recommendations for nursing research include replicating this study with contrasting scenarios, for example, eliminating staff nurse presence or eliminating staff nurse input. The study also should be replicated following implementation of nursing education recommendations. Another research recommendation is to study licensed RNs who have completed one year of practice to investigate whether the experiences of trusting and deference toward staff nurses translates into trusting and deference toward perceived superiors (e.g., managers, expert peers, or physicians). Because students reported that their ethical education was inconsistent and unapplied, another research recommendation is to evaluate nursing faculty experiences associated with teaching microethical decision making with the goal of understanding best teaching practices as well as challenges.

Finally, the EBP paradigm (Melnyk et al., 2009 , p. 50) does not explicitly incorporate applied ethics within the actions subsumed in the context of caring. The absence of explicit applied ethics language could influence how students learn to incorporate ethics within clinical decisions and perpetuate hidden or implicit ethics in nursing practice. Although modifications to the EBP framework are beyond the scope of this research study, findings certainly raise recommendations for future consideration.

Conclusion

Nursing students experience an inability to deliberately integrate ethical principles in microethical clinical decisions. Untimely, decontextualized ethics education does little to help students transfer

learning from the classroom into microethical nursing practice situations. Findings from this study highlight the importance of ensuring that students receive structured critical feedback from expert faculty with the goal of developing ethical habits, attitudes, and knowledge that are congruent with professional practice. Although students were able to recall and verbalize best-practice standards, they felt conflicted and torn about what they should do when faced with contextual microethical situations; therefore, students deferred to the advice of staff nurses regarding practice decisions. A redesign of ethical education, using an eclectic learning theory approach, offers opportunities to strengthen teaching strategies and enhance students' ability to engage in fully informed evidence-based, theory-guided, ethically reasoned patient care decisions.

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Table

Interview Protocol Questions

Microethical Experience Questions
Broad opening question: Reflect on the situation that occurred in the simulation laboratory and your nursing knowledge of best practices. What are your thoughts about what happened during the simulation?
Probing questions (as needed): How did you feel during the simulation? Was there a moment during the simulation when you felt sure or unsure about what to do?
Broad question: Now that you are on the cusp of nursing practice, how would you describe your experiences associated with learning how to incorporate ethical decision making into your nursing practice?
Probing questions (as needed): How do you feel that your nursing education has prepared you to make clinical decisions? Based on your experiences, what educational experiences do you think were most meaningful?
Closing question: Is there anything else you would like to add?

Footnote

The authors have disclosed no potential conflicts of interest, financial or otherwise.

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