

3-2015

Development and Reliability Testing of a Survey: Measuring Trusting and Deference Behaviors in Microethical Nursing Practice

Loretta C. Krautschied
University of Portland, krautsch@up.edu

Justin Britton

Carol Craig
University of Portland, craig@up.edu

Follow this and additional works at: http://pilotscholars.up.edu/nrs_facpubs



Part of the [Nursing Commons](#)

Citation: Pilot Scholars Version (Modified MLA Style)

Krautschied, Loretta C.; Britton, Justin; and Craig, Carol, "Development and Reliability Testing of a Survey: Measuring Trusting and Deference Behaviors in Microethical Nursing Practice" (2015). *Nursing Faculty Publications and Presentations*. 14.
http://pilotscholars.up.edu/nrs_facpubs/14

This Journal Article is brought to you for free and open access by the School of Nursing at Pilot Scholars. It has been accepted for inclusion in Nursing Faculty Publications and Presentations by an authorized administrator of Pilot Scholars. For more information, please contact library@up.edu.

Development and Reliability Testing of a Survey: Measuring Trusting and Deference Behaviors in Micro-Ethical Nursing Practice

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 pre-licensure ethical education requirements and practice guidelines from professional nursing agencies (AACN, 2008; ANA, 2010; ICN, 2006), 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; i.e., *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. Post-licensure novice nurses who experienced *trusting and deference* as students may be habituated to continue these behaviors in their post-licensure practice. This pilot study utilized a descriptive cross-sectional survey design to evaluate a researcher-developed survey examining the prevalence of *trusting and deference* behaviors during micro-ethical clinical practice decisions among novice acute care nurses during their first year of post-licensure practice.

Literature Review

Nursing, allied-health, and ethics literature sources were searched using the following key words: *micro-ethics, 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 micro-ethical

practices among post-licensure 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 post-licensure nurses associated with making micro-ethical clinical practice decisions. Additionally, no survey instruments were located in the literature that have studied the prevalence of *trusting and deference* behaviors among novice post-licensure nurses.

An operational definition of *micro-ethical nursing practice* is needed to provide context for this research. According to Worthley (1997), micro-ethical decisions are the day-to-day clinical practice situations that nurses routinely encounter. Micro-ethical 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” (Brigid, 1998, p. 1135). Micro-ethical situations reported in the literature include determining whether to leave medications unattended at the 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; Cohen & Erickson, 2006; Kalvemmark, Hoglund, Hansson, Westerholm, & Arnetz, 2004; Mortell, 2012; Murray, 2010; van der Arend & Remmers-van den Hurk, 1999; Worthley, 1997). In contrast, macro-ethical decisions are associated with bio-ethical issues, e.g., initiating or discontinuing life support or determining which patient should receive a donor organ for transplant. The current authors elected to focus on micro-ethical issues in nursing practice because these issues routinely occur and, as previously noted, are likely to be obscure and 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; i.e., 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 the patient, contradict evidence-based practice (EBP), or cause the student to engage in substandard care. Similar conceptualizations of *trusting* were revealed in Brigid's (1998) study of novice post-licensure 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 micro-ethical practices for the following reasons: they lacked sufficient confidence, they felt powerless to

contradict the staff nurse, and they didn't know if the advice was incorrect given the specific clinical context; i.e., the students had contextual naïveté (Krautscheid & Brown, 2014). Similar conceptualizations of *deference* were noted in Brighid's (1998) study. Novice post-licensure nurses felt vulnerable to social pressures in the workplace, 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 micro-ethical clinical situations among student nurses and novice post-licensure nurses. In a qualitative study of undergraduate baccalaureate senior nursing students, Krautscheid and Brown (2014) reported that when nursing students were confronted with a micro-ethical clinical decision, they demonstrated 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 post-licensure 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 micro-ethical 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 post-licensure 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 micro-ethical clinical situation 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 micro-ethical 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 post-licensure 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.

As might be expected, 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 describe both student nurse and post-licensure nurse experiences with moral distress, moral sensitivity, 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, Braga, Godoy, Spiri, & Bocchi, 2008; Bicking, 2011; Gropelli, 2010; Kalaitzidis & Schmitz, 2011; Markkula Center, 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 student nurses 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 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 post-licensure nurses are most likely to experience micro-ethical decision-making challenges, a consistent finding shows that nurses across the novice-to-expert spectrum (Benner, 2000) experience micro-ethical 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 is to evaluate a researcher developed survey designed to explore the prevalence of trusting and deference behaviors among post-licensure 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 a survey instrument. The instrument was reviewed by three PhD-prepared nurse educators to evaluate content validity. An item-level content validity index (I-CVI) was calculated for each survey item and 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 (IRB) 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. 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.

Sample

A convenience sampling strategy was used. Email 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 (CCNE) 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 x 70%). Participants were included if they had been employed as a registered nurse (RN) in an acute-care or sub-acute rehabilitation setting for at least three 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 assuring anonymity.

A total of 97 alumni responded to the survey. Eighteen alumni were excluded from participation because they failed to meet inclusion criteria; e.g., length of time working and work setting. Six participants were removed from the study because they completed less than 87% of the survey; i.e., 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, in their 20s, and the average length of time working was 9.85 months. Table 1 presents participant demographics.

Insert Table 1 about here

The SON curriculum provides formal ethics education in a 200-level course as well as formal and non-formal 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 email invitations (at week one and week two). Data collection ended three weeks after the initial invitation was sent.

Findings

Survey findings are presented in Table 2.

Insert Table 2 about here

The original 16 item pilot survey as written demonstrated a reliability of $\alpha = 0.657$. Factor analysis (Table 3) revealed four factors and a Chronbach's alpha was computed for each factor: (a) *deference behaviors* (5 items, $\alpha=0.80$); (b) *ethical, evidence-based practice behaviors (EEBP)* (4 items, $\alpha=0.78$); (c) *trust behaviors* (4 items, $\alpha=0.425$); and (d) *pressure to conform* (3 items, $\alpha=0.596$). Factor analysis was used to reduce the number of survey variables resulting in a nine-item survey with a Chronbach's alpha of 0.80 for the factors *deference behaviors* and *ethical, evidence-based practice behaviors*.

Insert Table 3 about here

Factor analysis revealed that five of the items reliably measured the prevalence of *deference behaviors* to advice from experienced nurse coworkers that deviated from evidence-based practice: questions 3, 5, 6, 9, and 13 (5 items, $\alpha=0.80$). Nurses in the sample reported that when they received advice that they knew deviated from evidence-based practice, 30 to 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 to 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 *ethical, evidence-based practice (EEBP) behaviors*: questions 8, 11, 12, and 16 (4 items, $\alpha=0.78$). Findings revealed that when study participants received advice that deviated from evidence-based practice, 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, $\alpha=0.42$): 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 to 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 to 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 to 30% of the time ($x=2.87$).

Factor analysis revealed that three items demonstrated a low level of reliability (3 items, $\alpha=0.59$) 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 time they were told, “This is how things are done in the real world” ($x=3.16$).

Discussion, Limitations, and Recommendations

Study findings 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 micro-ethical practice challenges, having faith in the opinion of an experienced nurse co-worker, lacking confidence, and wanting to avoid conflict were the most prevalent reasons associated with *deferring* to advice that deviated from EBP. While participants were practicing nursing under the authority of their own license, 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 upon the specific context of the situation, deferring to advice that deviates from 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 post-licensure education.

An important finding in this study was the reported prevalence of deferring to advice that deviated from EBP so as to avoid conflict (10 to 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).

Limitations of the study included a small sample size, low response rate, and all participants were recruited from one site; i.e., 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 the majority of students who graduate from pre-licensure 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; i.e. 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 nurses personal needs.

An eclectic learning theory approach is recommended to assist nurses in learning how to apply an ethics of care in their practice. Transformational learning theory (Mezirow, 2000) in combination with behavioral learning theory (Skinner, 1974, Schunk, 2004) 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 non-actions extend beyond themselves and their co-workers while emphasizing nurse-patient relationships leading toward sound decisions that promote optimal well-being.

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

This pilot study revealed that nine items in the original 16-item survey instrument demonstrated 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 *ethical, evidence-based practice behaviors* scale (DeVellis, 2003). The methodological study would incorporate a larger and more diverse sample. The methodological study should be conducted prior to using the survey instrument. Once the instrument has been re-tested with a larger sample in both academic and clinical practice settings, survey findings

would help target educational strategies toward the most prevalent issues. Finally, this study found that 30 to 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 co-workers, particularly when the advice is known to deviate from EBP.

Findings from this study offer insights about the prevalence of deference behaviors among novice, post-licensure nurses during micro-ethical 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 micro-ethical issues in everyday practice.

References

- American Association of Colleges of Nursing. (2008). The essentials of baccalaureate education for professional nursing practice. Retrieved from <http://www.aacn.nche.edu/education-resources/baccessential08.pdf>.
- American Nurses Association. (2010). Code of ethics for nurses with interpretive statements. Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf>
- Benner, P. (2000). *From novice to expert: Excellence and power in clinical nursing practice*. Upper Saddle River, NJ: Prentice Hall.
- Berti, H., Braga, E., Godoy, I., Spiri, W., & Bocchi, S. (2008). Movement undertaken by newly graduated nurses towards the strengthening of their professional autonomy and towards patient autonomy. *Rev Latino-am Enfermagem*, 16(2), 184-191.
- Bicking, C. (2011). Empowering nurses to participate in ethical decision-making at the bedside. *The Journal of Continuing Education in Nursing*, 42(1); 19-26.
- California Board of Registered Nursing. (2013). Disciplinary actions and reinstatements. Retrieved from <http://www.rn.ca.gov/enforcement/dispaaction.shtml#actions>
- Cameron, M., Schaffer, M., & Park, H. (2001). Nursing student's experience of ethical problems and use of ethical decision-making models. *Nursing Ethics*, 8(5), 432-447.
- Carlson, S., Kotze, W., & van Rooyen, D. (2005). Experiences of final year nursing students in their preparedness to become registered nurses. *Curationis*, 28(4), 65-73.
- Cohen, J., & Erickson, J. (2006). Ethical dilemmas and moral distress in oncology nursing practice. *Clinical Journal of Oncology Nursing*, 10(6), 775-781.

- Corley, M. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics*, 9(6), 636-650.
- Deshpande, S., Joseph, J., & Prasad, R. (2006). Factors impacting ethical behavior in hospitals. *Journal of Business Ethics*, 69, 207-216. doi: 10.1007/s10551-006-9086-5.
- DeVellis, R. (2003). *Scale development theory and applications*. Thousand Oaks, CA: Sage Publications.
- Dierckx de Casterle, B., Grypdonck, M., & Vuylsteke-Wauters, M. (1997). Development, reliability, and validity testing of the Ethical Behavior Test: A measure for nurses' ethical behavior. *Journal of Nursing Management*, 5(1), 87-112.
- Dierckx de Casterle, B., Shigeko, I., Godfrey, N., & Denhaerynck, K. (2008). Nurses' responses to ethical dilemmas in nursing practice: Meta-analysis. *Journal of Advanced Nursing*, 63(6), 540-549.
- Eby, R., Hartley, P. L., Hodges, P. J., Hoffpauir, R., Newbanks, S., and Kelley, J. H. (2013). Moral integrity and moral courage: Can you teach it? *Journal of Nursing Education*, 52(4), 229-233.
- Epstein, E. G., & Delgado, S. (2010). Understanding and addressing moral distress. *Online Journal of Issues in Nursing*, 15(3), 1.
- Flateau-Lux, L., & Gravel, T. (2013). Put a stop to bullying new nurses. *Nursing 2013*, June, 24-29.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Gropelli, T. (2010). Using active simulation to enhance learning of nursing ethics. *The Journal of Continuing Education in Nursing*, 41(3), 104-105.

- Iglesias, M., & Vallejo, R. (2012). Conflict resolution styles in the nursing profession. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 43(1), 73-80. doi: 10.5172/conu.2012.43.1.73
- International Council of Nurses. (2006). *Code of ethics for nurses*. Retrieved from http://www.dsr.dk/ser/Documents/icncode_english.pdf
- Kalvemark, S., Hoglund, A., Hansson, M., Westerholm, P., & Arnetz, B. (2003). Living with conflicts; Ethical dilemmas and moral distress in health care systems. *Social Science and Medicine*, 58, 1075-1084.
- Kalaitzidis, E., & Schmitz, K. (2011). A study of an ethics education topic for undergraduate nursing students. *Nursing Education Today*, 32, 111-115.
- Lachman, V. (2010). Strategies necessary for moral courage. *The Online Journal of Issues in Nursing*, 15(3). doi: 10.3912/OJIN.Vol15No03Man03.
- Lachman, V. D. (2014). Ethical issues in the disruptive behaviors of incivility, bullying, and horizontal/lateral violence. *MEDSURG Nursing*, 23(1), 56-60.
- Markkula Center for Applied Ethics. (2012). Ethical decision making. Retrieved from <http://www.scu.edu/ethics/practicing/decision/>
- Mezirow, J. (2000). *Learning as transformation: Critical perspectives on a theory in progress*. San Francisco, CA: Jossey-Bass.
- Miller, J. (2006). Opportunities and obstacles for good work in nursing. *Nursing Ethics*, 13(5), 471-487.
- Mortell, M. (2012). Hand hygiene compliance: Is there a theory-practice-ethics gap? *British Journal of Nursing*, 21(17), 1011-1014.

Murray, J. S. (2010). Moral courage in healthcare: Acting ethically even in the presence of risk.

Online Journal of Issues in Nursing, 15(3): 1. doi:

<http://dx.doi.org/10.3912/OJIN.Vol15No03Man02>.

Oregon State Board of Nursing. (2013). Public disciplinary actions taken by the Board of

Nursing. Retrieved from http://www.oregon.gov/OSBN/pages/online_records.aspx.

National Student Nurses Association. (2009). Code of ethics: Part II. Retrieved from

http://www.nсна.org/portals/0/skins/nsna/pdf/nsna_coc_academic_clinical_interp_statements.pdf

Polit, D., Beck, C., and Owen, S. (2007). Is the CVI an acceptable indicator of content validity?

Appraisal and recommendations. *Research in Nursing and Health*, 30, 459-467.

Raines, M. (2000). Ethical decision making in nurses: Relationships among moral reasoning,

coping style, and ethics stress. *Healthcare Law, Ethics, and Regulation*, 2(1), 29-41.

Schunk, D. (2004). Learning theories. An educational perspective. Upper Saddle River, NJ:

Pearson.

Skinner, B. F. (1974). About behaviorism. New York: Vintage Books.

Vagias, W. M. (2006). Likert-type scale response anchors. Clemson International Institute for

Tourism & Research Development, Department of Parks, Recreation and Tourism

Management. Clemson, SC: Clemson University.

van der Arend, A., & Remmers-van der Hurk, C. (1999). Moral problems among Dutch nurses:

A survey. *Nursing Ethics*, 6(6), 468-482.

Washington State Department of Health. (2012). Health professional discipline and regulatory activities. Retrieved from

<http://www.doh.wa.gov/Portals/1/Documents/2000/UDARreport2009-2011.pdf>

Webster, G., & Bayliss, F. (2010). Moral residue. In S. Rubin & L. Zoloth (Eds), *Margin of error: The effects of mistakes in the practice of medicine*. Hagerstown, MD: University.

Worthley, J. A. (1997). *The ethics of the ordinary in healthcare*. Chicago, IL: Health Administration Press.

Table 1.

Participant Demographic Data (n=73)

Demographic	Mean (SD)
Months working as an RN	9.85 (4.94)
Age	25.01 (4.79)
	n (%)
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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-worker, 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 co-worker, how often are you told "This is how things are done in the real world"?	3.16 (1.61)
16. When experienced nurse co-workers' advice deviates from evidence-based practice, how often do you remember to use ethical standards to guide decision making?	5.13 (1.49)

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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-workers 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 co-worker, 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 co-worker, how often are you told "This is how things are done in the real world"?	.440	-.165	-.043	.544

16. When experienced nurse co-workers' 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 > 0.50 are in boldface.