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**Micro-ethical decision making among baccalaureate student nurses: A qualitative
investigation**

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Abstract

Background. Student nurses are frequently exposed to micro-ethical, every-day nursing practice problems during their clinical practicum. Little is known, however, about how students learn, rehearse, and intentionally incorporate ethical principles in the fast-paced and contextual clinical practice environment.

Research objective. The purpose of this qualitative research was to understand the lived-experiences of senior-level baccalaureate nursing students who are faced with making micro-ethical clinical decisions in acute-care clinical practice settings.

Research design. An interpretive phenomenological design was utilized, resulting in the emergence of five central themes. Institutional Review Board (IRB) approval was obtained. Participants (n=7) were senior-level students in the final semester of their baccalaureate program. After obtaining informed consent, data collection occurred via face-to-face semi-structured interviews.

Findings. Findings revealed a web of meanings attributed to learning and applying ethical principles in nursing practice. Participants described taking undergraduate classes where they were exposed to ethical standards, but viewed the academic education as philosophical and detached from every-day clinical decision-making. A dominant finding was the experience of unapplied and neglected ethics education revealing a mismatch between what faculty perceived was being taught and the students' experience of that education. When faced with micro-ethical decisions, participants readily exhibited trusting and deference toward clinical faculty recommendations, even if the advice contradicted best-practice standards. Participants reported they frequently engaged in reality testing, attempting to reconcile academic knowledge, best practice standards and advice from faculty in the clinical environment. In the midst of reality testing, students' contextual naivety was brought out of concealment, contributing meanings to further understand prior themes. Finally, participants gave language to the experience of moral disequilibrium, stating they felt conflicted, confused, and torn between best practices learned in school and what they see role-modeled in the clinical environment.

Discussion. This study resulted in theory-guided implications for nursing education, recommendations for future study, and a proposal to modify existing evidence-based practice conceptual frameworks.

Micro-ethical decision making among baccalaureate student nurses: A qualitative investigation

Student nurses are frequently exposed to micro-ethical nursing practice problems during clinical practicum. Little is known, however, about how students intentionally incorporate ethical principles within their decision-making processes at the point of care. The purpose of this qualitative research was to understand the lived experiences of senior-level baccalaureate nursing students confronted with a clinical scenario that required micro-ethical decision-making.

Micro-ethics, according to Worthley (1997), are the every-day ethical decisions that practicing nurses make within the context of common or routine clinical situations. Conversely, macro-ethics refers to extraordinary bio-ethical situations; e.g. abortion and initiating or withholding life-sustaining treatments. An example of a micro-ethical 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 micro-ethical situations, such as the aforementioned medication administration example, they experience confusion, psychological disequilibrium and moral distress (Gallagher, 2010). "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" (Callister, Luthy, Thompson & Memmott, 2009, p. 500). Students at the authors' academic institution have

reported experiencing micro-ethical issues and ambivalence between what they have seen role-modeled in clinical and what is taught in didactic courses built upon evidence-based practice (EBP).

Micro-ethical 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 don't know what *to do*, instead the problem may be that people don't know what they *should do*. Nurses rely on EBP to inform what *to do*. "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" (Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2009, p. 51). Evidence, clinical expertise and patient preferences, however, do not provide adequate resources to resolve ethical issues. Resolving micro-ethical 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 (Campbell, 1990; Callister et al., 2009; Sarvimaki, 1995; van Hooft, 2006). The aim of this study is 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: *healthcare ethics, micro-ethics, nursing education, ethical decision-making, learning, teaching, 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 the students lived experiences associated with ethics education and incorporating ethical principles during micro-ethical 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 macro-ethics as well as the micro-ethics levels. Micro-ethical issues are frequently discussed 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 short-cuts that diverge from EBP standards, placing patients at risk for injury. “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*” (Day & Smith, 2007, 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, Soitysik & 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 the student 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 the student to explore converging values, challenge assumptions, and critically reflect on professional practice (Benner et al., 2010; Callister, et al., 2009; Cameron, Schaffer & Park, 2001). A noted gap in the literature was empirical evidence about the experiences of baccalaureate nursing students (BSN) and how they incorporated such ethics education within micro-ethical clinical practice decisions.

Methods

This qualitative study explored the experiences of BSN senior-level students who encountered a micro-ethical issue in a simulated clinical environment. Institutional Review Board (IRB) 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 subjects recruit additional subjects from among their peer group. Researchers invited all eligible students to participate. Enrolled subjects were then asked to recruit additional study participants. Recruitment ended when thematic saturation was achieved. Senior-level BSN students at the researchers' academic institution were invited via email and no grade or financial incentives were offered. Anonymity was assured by assigning an identifying number to each participant. Data was collected via one-on-one semi-structured interviews, each lasting approximately 65 minutes.

The sample consisted of seven students in a private, faith-based BSN program in a Northwest region of the United States. Participant ages ranged from 21 to 23 (average 21.4 years old). Two participants were male and five were female. 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 macro-ethical healthcare situations. Additional ethics education was threaded within upper division nursing courses; e.g. discussions about the ANA *Code of Ethics*, bioethical case studies, as well as both structured and coincidental clinical exposure to ethical situations. After signing the consent form, participants demonstrated clinical decision-making in a 15 minute high-fidelity simulation (Lasater, 2007), at the researchers' academic institution. The simulation was not recorded and anonymity was protected. The purpose of the simulation was to replicate an authentic micro-ethical clinical experience. The student was to administer scheduled medications (anti-hypertensive and diuretic) to a patient (human 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 phone call. The patient was scripted to indicate they 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 micro-ethical decision about safe medication administration; i.e. deciding what a nurse *should* do to positively influence patient care. This scenario was specifically selected 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 lab.

Immediately following the simulation, participants engaged in a one-on-one semi-structured interview utilizing a researcher developed interview protocol that had been field-tested by three qualitative research experts.

Micro-ethical Experience Questions
<p>Broad opening question: Reflect on the situation that occurred in the simulation lab and your nursing knowledge of best practices. Tell us, what are your thoughts about what happened during the simulation?</p> <p>Probing questions (as needed) How did you <i>feel</i> during the simulation? Was there a moment during simulation when you felt sure and/or unsure about what to do?</p>
<p>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?</p> <p>Probing question (as needed) How do you <i>feel</i> that your nursing education has prepared you to make clinical decisions? Based on your experiences, what educational experiences do you think were most meaningful?</p>
<p>Closing question: Is there anything else you would like to tell us?</p>

Figure 1. Interview Protocol Questions

Interviews were audiotaped and transcribed verbatim. Transcript verification occurred by listening to the audiotapes while reading the transcripts. The editing analysis style was utilized throughout data reduction and data construction. Data was 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 micro-ethical clinical decision emerged from the data.

Ethics education: unapplied and forgotten

Participants were asked to reflect upon educational experiences and describe how they felt 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. One participant said, “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.” According to another participant, “sometimes it is really easy to just forget about that stuff that you have been taught.” Other participants described similar experiences stating, “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 utilize legitimate ethical principles and intentionally apply these in professional practice.

Despite the inability to recall and deliberately apply ethical principles, language emerged from the text data revealing experiences of ethical formation through the hidden curriculum and non-formal educational experiences; e.g. the influence of observed clinical experiences and the role one’s upbringing contributes to moral development. One participant said, “clinical itself has really helped me. Seeing mistakes by other nurses and peers has truly made me more aware of ethical dilemmas.” Another said, “what prepares me to make ethical

decisions in clinical is having those terms brought up in the context where I can understand them.” And a final participant stated, “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 micro-ethical clinical decisions. “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.” According to another participant, “A lot of this has to do with my upbringing.” Another participant stated, “[regarding ethics] it’s 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 upon 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 wellbeing at risk. The findings support the literature (Dohmann, 2009; Kalaitzidis & Schmitz, 2012) and suggest a connection between random and non-formal 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 student stated, “it’s there somewhere.” This insightful quote highlights the meaning of preconscious thinking; i.e. 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. One participated commented, “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.” According to another student, “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.” Another stated, “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. “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” (Green, 2012, p. 1). Care ethics text data was found in this study. One participated stated, “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.” Another student said, “patient

autonomy, obviously the patient's wishes are my first thought. If someone [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." Other participants made similar statements such as, "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 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 micro-ethical 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 upon staff nurses for advice and guidance.

Trusting and deference

Participants were asked to reflect upon their actions in the simulation, their knowledge of best practice and 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. One participant stated, "I kind of gave him [nurse] a look like – I'm not really sure if this is right. But he seemed really confident with leaving it [medications] 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. they are perceived as unquestionably trustworthy.

A preponderance of data revealed that when students are faced with ambiguous micro-ethical decisions, they primarily seek out staff nurse advice rather than contemplating ethical options and potential outcomes; trusting nurses to act as a safety-net and intervene in potentially unsafe situations. According to one student, "I thought they [staff nurse] 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, um, but in that situation, I went, well, my nurse felt comfortable, so I followed his lead." Other participants also talked about trusting staff nurses stating, "they agreed [to leave medications], so it must be right." "It is really nice to have the nurse there as your life line." These exemplar statements explicitly revealed trusting staff nurse 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 this student's observations, "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 micro-ethical principles within a contextually challenging scenario. According to van Hooft (2006) applied ethical issues arise when there is conflict between one's conscience, professional role and planned actions. Conflict is noted, albeit subtly, in participant comments that suggested contemplating the best course of action, but ultimately yielding to the advice of the staff nurse and engaging in actions that contradict best practice standards. This finding highlights the importance of student-staff

nurse relationships, specifically the influence esteemed superiors have on guiding or misdirecting students' micro-ethical decision-making.

A higher view of the text data within the theme, *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 (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 may become reliant on nurses to identify situations as having a micro ethical 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 naivety

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 said, "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." Another participant indicated, "you [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.” According to another participant, “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.... like 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?” And according to another participant, “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 micro-ethical situations is dependent upon the worldview and socially constructed meanings of the involved individuals.

Reality testing in contextual situations is further understood through the meanings associated with inexperience, naivety and an inability to project potential consequences of action or inaction. The theme, *contextual naivety*, was brought out of concealment in the following text data. “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.” Another student said, “I would’ve 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.” According to another participant, “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 at the bedside.” These participant comments reveal naivety 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, represents 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 naïve* 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 naivety*, 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 if 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 provides 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 naivety* 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.

Approximately half-way through the interviews, however, participants began to describe feeling

confused, conflicted, and torn. While 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, their nursing practice decision and were beginning to doubt if leaving the medication was the right and ethical thing to do. According to one participant, “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.” Another said, “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.” According to this student, “leaving the medication on the bedside is something that we’re kind of always told not to do you know, the big no-no.” Students also discussed feeling torn about their decision, stating, “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.” These participants’ comments reveal reflective thinking that occurred after the simulation.

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 didn’t work, and potential future actions that will assist them to be more effective (Johns, 1995). Reflection helps one to improve ethical decision making, “provided we understand what went wrong” (van Hooft, 2006, p. 24). The findings from this theme highlight the importance of intentionally engaging students in real-world micro-ethical situations with subsequent facilitated reflection to improve ethical decision-making.

Discussion, Limitations and Recommendations

Study findings validate current evidence in the literature and provide new evidence upon which to understand how students experience ethical education and make micro-ethical clinical decisions. Study findings are limited to the experiences of BSN students, enrolled at a faith-based, private academic institution, who volunteered to participate. Another noteworthy limitation is the participant's average age (21.4 years). While the average age is reflective of the nursing student population at the author's academic institution (mean BSN student age is 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 Done, 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 this 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 previously 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, Cafarella & 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, theorizes 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 micro-ethics 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 micro-ethical 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 micro-ethical 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 post-licensure 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 micro-ethical decision-making and critical reflection on teaching practices (Brookfield, 1995), explicitly focusing on how one teaches and role-models micro-ethical 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 micro-ethical 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; e.g. eliminating staff nurse presence or eliminating staff nurse input. The study should also be replicated following implementation of nursing education recommendations. Another research recommendation is to study licensed registered nurses who have completed one year of practice to investigate if 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 micro-ethical 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. Modifications to the EBP framework are beyond the scope of this research study, but certainly raises recommendations for future consideration.

Conclusion

Nursing students experience an inability to deliberately integrate ethical principles in micro-ethical clinical decisions. Untimely, decontextualized ethics education does little to help students transfer learning from the classroom into micro-ethical 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. Though students were able to recall and verbalize best practice standards, they felt conflicted and torn about what they *should* do when faced with contextual micro-ethical situations; therefore, students deferred to the advice of staff nurses regarding practice decisions. A redesign of ethical education, utilizing 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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