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Nurses' responses to ethical dilemmas in nursing practice: meta-analysis

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Abstract

Title. Nurses' responses to ethical dilemmas in nursing practice: meta-analysis.

Aim. This paper is a report of a study to explore nurses' responses to ethical dilemmas in daily nursing practice.

Background. Concern about nurses' ethical competence is growing. Most nurses perceived that there were barriers in their work environment to ethical practice, compromising their ability to perform ethically. Since most research focuses on contextual barriers to nurses' ethical practice, little is known about how nurses involve themselves in ethical decision-making and action in daily care.

Method. A meta-analysis of nurses' ethical behaviour was conducted using data from nine studies in four countries (n = 1592 registered nurses). In all studies, the Ethical Behaviour Test was used to measure nurses' ethical responses, based on an adapted version of Kohlberg's theory of moral development. Data were analysed using random-intercept regression analysis.

Findings. All groups, except the expert group, displayed a uniform pattern of conventional ethical reasoning and practice. When nurses were faced with ethical dilemmas, they tended to use conventions as their predominant decision-guiding criteria rather than patients' personal needs and well-being.

Conclusion. Conformist practice (following conventions rather than pursuing good for the patient) constitutes a major barrier for nurses to take the appropriate ethical actions, as creativity and critical reflection are absent. There is an urgent need to find ways to promote nurses' ethical development from conventional to postconventional ethical practice. More research is needed to strengthen existing empirical evidence.

Keywords: Ethical Behaviour Test, ethical decision-making, ethical dilemmas, Kohlberg, meta-analysis, moral development, nursing

Introduction

Changes in health care and society have led to new and increased awareness of the ethical dimension of nursing and its impact on the delivery of high-quality care (Coverston & Rogers 2000). In their daily practice, nurses are constantly confronted with decision-making that is ethical in nature. In a study of ethical decision-making, Raines (2000) found that oncology nurses experienced, on average, 32 different types of ethical dilemmas during a 1-year period, with many of these events taking place daily. Most frequently cited dilemmas dealt with pain management, cost containment issues and quality-of-life and other decisions relating to a patient's best interest (Raines 2000). In general, technological and medical advances, the growing complexity of care situations and the lack of evidence-based interventions

require nurses constantly and critically to reflect on how they can contribute to their patients' well-being, which in turn requires that they possess high-level professional competence and ethical maturity (Spitzer 1998, Coverston & Rogers 2000, Plsek & Greenhalgh 2001).

The ongoing focus on the technical aspects of nursing often obscures concerns relating to the ethical practices of nurses (Sorlie *et al.* 2003). No matter how important technical and scientific expertise in nursing may be, providing good nursing care is always an ethically grounded undertaking. Nursing is primarily oriented to making explicit and to achieving what is good for a specific patient. The ethical concern for a patient's well-being is fundamental to the ethical demand that inspires nursing practice (Bishop & Scudder 1990, Gastmans *et al.* 1998). Thus, nurses not only have to show how their (evidence-based) practice can be both clinically and cost effective, but also that this care contributes to the full appreciation of the patient as a human being (Kitson 1996).

However, in clinical practice, as well as in the literature, there is a growing concern about implementing ethical nursing practice. Ethical practice seems most problematic in daily ethical dilemmas, arising from situations that involve conflicting values or beliefs about what is the right or best course of action (Ham 2004). Most nurses seem to be ill-prepared to address ethical dilemmas. Botes (2000) findings revealed that nurses do not think critically when making ethical decisions. The critical care nurses in Gutierrez's (2005) study described a variety of situations that conflicted with their ethical values and in which they were expected to implement actions that they perceived to be ethically wrong. Raines (1994) and Whitler (1996) also observed a lack of congruence between nurses' values or ethical decisions and the actions they implemented in practice. The conflict between personal values and professional responsibility is also echoed by Turner *et al.* (1996). According to nurses, it is virtually impossible to practise according to one's own ethical values or to voice ethical problems within the team (Sorlie *et al.* 2003, Varcoe *et al.* 2004, Siebens *et al.* 2006).

Consistent with this perception is their view that there were barriers to ethical practice in their work environment, compromising their ability to provide competent and compassionate care (Erlen 2001, Gutierrez 2005). Indeed, heavy workloads, insufficient time, organizational and financial constraints and staffing problems often make it difficult for nurses to make ethically-based decisions a priority in their practice (Ham 2004, Torjuul & Sorlie 2006). Contextual barriers to ethical practice are also evident in findings from newly qualified nurses, which reveal that new graduates initially base their actions on individual ethical codes (Ham 2004), only to succumb gradually to environmental pressures to conform (Kelly 1998, Ham 2004).

Because most nursing ethics literature focuses on external and contextual barriers to ethical nursing practice, little is known about how nurses involve themselves in ethical decision-making and action (McAlpine *et al.*1997, Doane *et al.* 2004). It is clear that nurses' ethical practice is not yet well-understood. Promoting ethical practice among nurses requires better understanding of the difficulties they experience when they use ethical values to guide their care decisions, and of the impact these difficulties may have on nurses' practice.

Background

In the present study, we used an adapted version of Kohlberg's theory to investigate nurses' responses to ethical dilemmas. Kohlberg (1976) identified three levels of moral development: preconventional, conventional and postconventional (see Table 1). The distinction between the different levels lies in the differences in the way in which people understand and use 'conventions' in complex ethical decision-making. Conventions are the rules, norms, expectations and laws in society or in groups (such as the nursing profession, hospital and nursing unit). Each level of moral development consists of two stages, the second of which reflects a more developed and better-organized pattern of thinking.

The cognitive-structural framework of Kohlberg's theory is useful for examining how nurses make ethical decisions and, more specifically, for determining whether they are able to reflect critically on their practices in terms of ethical principles (Dierckx de Casterlé *et al.* 1998). Individuals at the preconventional level (stages 1 and 2) of moral development have yet to come really to understand and uphold the conventions, let alone to reflect on them and their value in care. Fear of punishment or hope of a reward tends to direct the reasoning of individuals at this level. Those at the conventional level (stages 3 and 4) base their ethical decisions on their desire to be well-liked or on a rigid adherence to

Table 1 Kohlberg's moral development stages

Preconventional	
Stage 1	Obedience and punishment
Stage 2	Self-interest orientation
Conventional	
Stage 3	Interpersonal accord and conformity
Stage 4	Authority and social-order maintaining orientation
Postconventional	
Stage 5	Social contract orientation
Stage 6	Universal ethical principles

Kohlberg (1981).

prescribed social norms or laws. Loyalty and conformity guide their behaviour. These individuals conform to and uphold the rules, norms and expectations of society just because these are society's rules, norms and expectations. Reflection in light of patient well-being is absent. Those at the postconventional level (stages 5 and 6) understand and accept society's conventions, but they do so by formulating general ethical principles that underlie these rules and by abiding with these principles. When these principles come into conflict with society's rules, postconventional individuals judge by principle rather than by convention. People at the postconventional level are capable of differentiating between expectations and rules, of examining and defining autonomously ethical values and principles and of critically considering, testing and redefining viewpoints in the light of their own ethical principles. At this level, ethical autonomy is considered to be a criterion of ethical maturity. Attaining the postconventional level appears to be an essential requisite to become an ethically competent nurse who pursues patients' well-being beyond norms.

Kohlberg's theory, however, needs to be adjusted in relation to nursing care (Dierckx de Casterlé *et al.* 1998). The abstract, rigid and justice-oriented ethical concept seems to be inadequate for nursing practice. Because nurses' ethical judgments are often based on the relationship with a particular patient in a particular situation, a more relational ethical concept is needed. While principle-oriented ethics and ethics of care are depicted in the literature as distinct frameworks, they clearly do not always represent discrete experiences for nurses. According to Cooper (1991), nurses rely on traditional ethical principles such as patients' rights, patient autonomy, nursing obligations as a beginning philosophical frame of reference. Within this structure, they incorporate the ethical elements of caring and connectedness which seem central to nursing practice. Promoting patient well-being requires making difficult decisions that involve a complex struggle of recognizing what well-being means for a particular patient in a particular life event. Thus, Dierckx de Casterlé *et al.* (1998) refined the abstract, justice-oriented ethical concept of Kohlberg – in terms of duties and rights, fairness and impartiality – by adding a care perspective. This fundamental change of the content relates mainly to the fifth and sixth stages of the theory and focuses on nurses' commitment to promoting patient well-being. As well as justice and other universal principles, patient well-being is proposed to be a fundamental criterion of judgment in ethical dilemmas (Dierckx de Casterlé *et al.* 1998). Although the adapted version still reflects a cognitivistic view of ethics, its value in shedding light on ethical nursing practice has been empirically supported in previous research (Dierckx de Casterlé *et al.* 1997, 1998).

This adapted version has been used as framework to develop the Ethical Behaviour Test (EBT) to measure nurses' ethical reasoning and practice in nursing dilemmas (Dierckx de Casterlé *et al.* 1997). The Defining Issues Test (Rest 1976) and the Nursing Dilemma Test (Crisham 1981) were used as paradigms for the EBT; both instruments were based on Kohlberg's theory of moral development.

The study

Aim

The aim of this study was to explore nurses' responses to ethical dilemmas in daily nursing practice.

Design

A meta-analysis using individual nurse data was conducted using data from nine studies exploring nurses' ethical reasoning and implementation of their ethical judgment in response to ethical dilemmas in nursing practice.

Sample

Principal investigators who requested the use of the EBT as an instrument to capture nurses' responses to ethical dilemmas were invited to submit their data for the meta-analysis (Dierckx de Casterlé *et al.* 1997), and all do so. All datasets but one were included in the meta-analysis; one study was excluded as only a part of the EBT was used.

All datasets used for this study were gathered in a cross-sectional way. Of the nine studies, four were performed in Belgium with different sample selections at different points in time between 1993 and 2001. Although all participants were registered nurses, a group in one of the Belgian studies (Dierckx de Casterlé 1993) was selected as 'the expert nurses'. In this particular study, 58 nurses who were known for their high-level ethical reasoning and practice were recruited through purposive sampling and by consulting lead nurses in nursing services (Dierckx de Casterlé *et al.* 1997). This group of expert nurses was considered as separate research sample for the purpose of the present study. The meta-analysis also included two studies conducted in Switzerland, two in the United States of America, and one in Japan. Combining data from these nine studies produced a large data set comprising 1592 registered nurses. An overview of the sample characteristics is presented in Table 2.

Table 2 Sample characteristics

Research group, date	Country	Setting (language)	Sample (*n*)	Sex: Female Male	Mean age (SD) range	Age distribution	
Dierckx de Casterlé (1993)	Belgium	Catholic University Leuven (Dutch)	Registered nurses (enrolled in Master's degree nursing programme) (*n* = 168)	63% 37%	–	–	
Caerlens and Derwael (1998)	Belgium	Academic Hospital (Dutch)	Registered nurses (*n* = 280)	86% 14%	34 (7·7) 20–56	17·5% 13·3% 24·3% 18·3% 19·4% 6·1% 1·1%	<25 25–29 30–34 35–39 40–44 45–49 >49
International Leadership Group (2001)	Belgium	Academic Hospital (Dutch)	Registered nurses (*n* = 169)	95% 5%	35 (8·2) 21–58	11·2% 15·1% 21·2% 20·1% 19·0% 6·7% 6·7%	<25 25–29 30–34 35–39 40–44 45–49 >49
International Leadership Group (2001)	Belgium	Academic Hospital (French)	Registered nurses (*n* = 284)	84% 16%	37 (8·4) 20–57	4·9% 14·6% 19·8% 18·5% 20·8% 13·0% 8·4%	<25 25–29 30–34 35–39 40–44 45–49 >49
International Leadership Group (2001)	Switzerland	Regional Hospital (German)	Registered nurses (*n* = 214)	82% 18%	39 (7·8) 20–58	2·2% 10·5% 16·2% 24·5% 21·4% 17·5% 7·9%	<25 25–29 30–34 35–39 40–44 45–49 >49
International Leadership Group (2001)	Switzerland	Regional Hospital (German)	Registered nurses (*n* = 144)	85% 15%	38 (9·2) 24–60	1·2% 19·8% 17·9% 18·6% 13·0% 13·0% 16·7%	<25 25–29 30–34 35–39 40–44 45–49 >49
Godfrey (1999)	USA, Missouri	– (English)	Registered nurses (*n* = 199)	91% 9%	35 (13·6) 18–64	36·2% 7·3% 6·8% 9·7% 11·6% 11·6% 16·9%	<25 25–29 30–34 35–39 40–44 45–49 >49
L. Robley (Kennesaw State University, Kennesaw, GA, unpublished research)	USA, Georgia	– (English)	Registered nurses (*n* = 34)	–	28 (8·2) 20–55	47·1% 20·6% 14·7% 8·8% 2·9% 2·9% 2·9%	<25 25–29 30–34 35–39 40–44 45–49 >49

Table 2 (*Continued*)

Research group, date	Country	Setting (language)	Sample (*n*)	Sex: Female Male	Mean age (SD) range	Age distribution	
Izumi (2007)	Japan	Local General Hospital (Japanese)	Registered nurses (*n* = 42)	98% 2%	37 (10·0) 22–58	10·6%	< 25
						19·2%	25–29
						17·0%	30–34
						8·6%	35–39
						25·6%	40–44
						8·6%	45–49
						10·6%	> 49
Dierckx de Casterlé (1993)	Belgium	Academic & Regional Hospitals (Dutch)	Registered nurses (*n* = 58)	76% 24%	–	1·7%	< 25
						37·9%	25–29
						37·9%	30–34
						8·6%	35–39
						8·6%	40–44
						3·5%	45–49
						1·7%	> 49

Data collection

The EBT was developed by Dierckx de Casterlé *et al.* (1997) and contains five stories depicting nurses in daily ethical dilemmas. Each story is followed by four questions that assess ethical reasoning, ethical practice and perceptions of the nursing dilemma.

Respondents were first asked to choose the most desirable of the proposed dilemma solutions (A or B) and then to value and rank five arguments supporting their choice of solution A or B. Each of the arguments represents a stage of Kohlberg's model, from stages 2 to 6. The 'ethical reasoning score' was measured in terms of a nurse's preference for postconventional (rather than conventional or preconventional) arguments in making an ethical decision. This score, which can range from 5 to 55 points, was calculated on the basis of the ranking of stage 5 and 6 (postconventional) arguments supporting the choice of solutions. Higher ethical reasoning scores indicate that a nurse prefers to follow ethical principles rather than conventional rules or self-centred interests in ethical decision-making.

The third question concisely describes four situations in which respondents might find it difficult to implement their decision. These situations contain statements referring to Kohlberg's preconventional and conventional stages (stages 1–4). For each of the situations, nurses were asked to assess the probability that they would implement their decision despite the described situational pressure. Raw scores from the third question were used to compute the 'implementation score,' a principal component that extracted common information about the implementation intentions of nurses subjected to different situations (Dierckx de Casterlé *et al.* 1997). Higher implementation scores correspond to lower probability that respondents would implement their decisions in practice. Reliability and validity of the Dutch questionnaire were thoroughly evaluated and found to be adequate for the purpose of this study (Dierckx de Casterlé *et al.* 1997). The Dutch questionnaire has been translated into English, French, German and Japanese.

Data analysis

We analysed the data using random-intercept regression analysis. The different samples were included as random effects, and gender was included as a controlling fixed effect. The explanatory value of the different samples was quantified by intraclass correlation, a measure expressing what proportion of the variability in a data set is attributable to random effect (i.e. between-sample differences). The alpha level was set at 0·05. Analyses were carried out using SAS version 9.

Results

Ethical reasoning

We assessed the ethical reasoning levels of nurses by analysing their mean ethical reasoning scores on the five dilemmas presented in the EBT. The scores of the different research groups are presented in Figure 1. The group of expert nurses (Belgium) scored the highest, with a mean score of 48·4. The mean scores of the other nine research samples varied from 39·8 (Japan) to 43·9 (a sample of nurses from an academic Flemish hospital in Belgium).

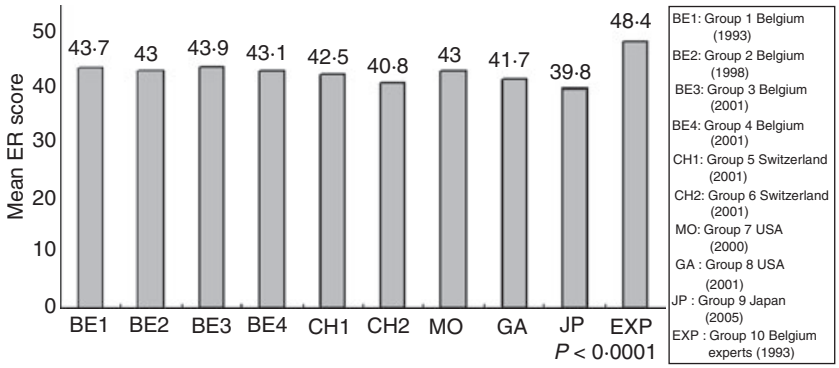

Figure 1 Mean Ethical Reasoning (ER) Scores (range 5–55).

The first four bars in Figure 1 represent Belgian research samples, arranged in chronological order: BE1 was the oldest sample and was obtained in 1993, followed by BE2, which was obtained in 1998; BE3 and BE4 were samples from studies conducted in 2001. The next bars represent Swiss (CH1, CH2) and American (MO, GA) ethical reasoning scores, followed by Japanese score (JP), which originated from a small-scale study conducted in 2005. The difference in ethical reasoning scores between the different samples was statistically significant ($P < 0{\cdot}0001$). This difference, however, can be mainly explained by the higher scores of the expert group, as illustrated by the interclass correlation, which decreased from 17% to 5% after we excluded the expert group from the analysis.

To understand the meaning of the ethical reasoning scores, we examined the underlying reasoning pattern of the respondents. This was achieved by analysing the individual ranking scores for each of the five Kohlberg stages across the five dilemmas. According to their ranking within each dilemma, the items received six, five, three, one or no points (Dierckx de Casterlé *et al.* 1997). The resulting mean ranking scores, which can range from zero to 30 points, are presented in Figure 2 for each group. These showed that nurses in general evaluated stage 5 arguments as the most important arguments to support an ethical decision. Stage 5 arguments correspond to the first stage of Kohlberg's postconventional level of moral development. Statements representing Kohlberg's fourth and sixth stages also seemed to play a relatively important role. Arguments corresponding to Kohlberg's second and third stages received the lowest ranking, suggesting that nurses did not consider these kinds of arguments to be important in helping them make an ethical decision. The plots of Figure 2 reveal a rather uniform pattern of reasoning by all research groups, except the expert group. In comparison with the expert group, nurses in general gave more importance to arguments corresponding to Kohlberg's fourth stage ($P < 0.0001$), less importance to arguments corresponding to Kohlberg's fifth stage ($P < 0.0001$), and even less importance to arguments corresponding to Kohlberg's sixth stage ($P < 0.0001$). Conversely, nurses from the expert group preferred arguments representing Kohlberg's sixth stage above those representing the fourth stage. Both groups considered stage 2 arguments (i.e. Kohlberg's preconventional level) to be less important. Stage 2 arguments received even less consideration from the expert group ($P < 0.0001$).

Ethical practice

We assessed the ethical practice of nurses by analysing the mean implementation scores for each group (Figure 3).

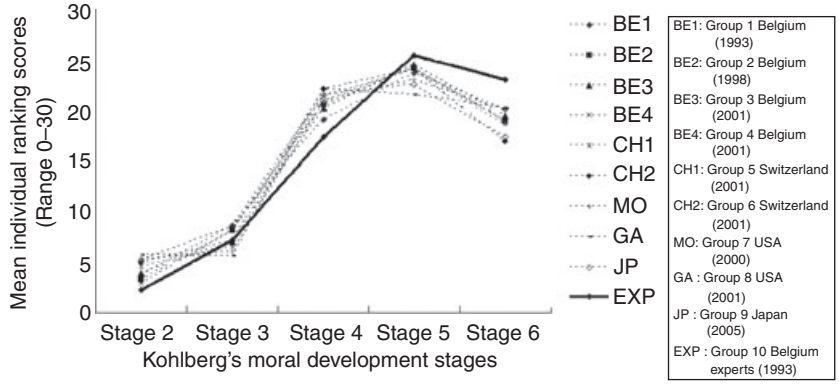

Figure 2 Mean individual ranking scores (range 0–30).

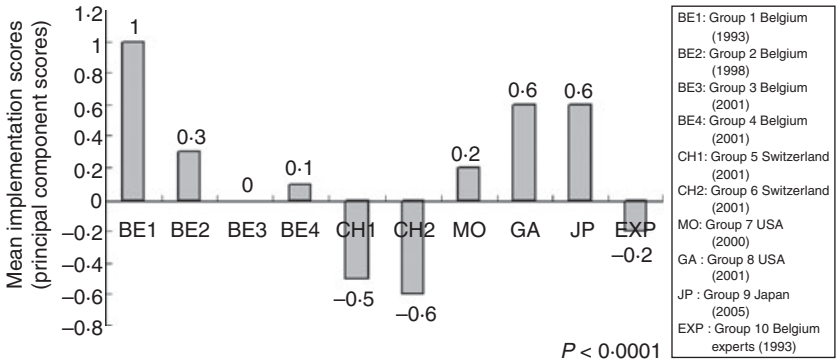

Figure 3 Mean implementation scores (Principal Component Scores) for each group.

Implementation scores measure the probability that a nurse will implement their own decision. We obtained these scores by assigning four, three, one or zero points to the respective situations described in question 3 of the EBT. These individual implementation scores were factor analysed. The mean implementation scores are principal component scores, calculated on the basis of the first principal component of this component analysis. High implementation scores indicate that a nurse has a low probability of implementing an ethical decision. The oldest Belgian sample (Dierckx de Casterlé 1993) had the highest implementation scores, whereas the two Swiss samples and the group of expert nurses had the lowest scores. Although these score differences were statistically significant ($P < 0.0001$), only 5% of the variance was explained by sample differences (expert group included).

To understand the meaning of these implementation scores, we analysed the individual implementation scores for each of the four situations that epitomize Kohlberg's preconventional and conventional levels of moral development (Figure 4). The higher the score, the more difficult it is for respondents to implement their ethical decisions. These scores revealed that nurses appear to have some difficulties in implementing their ethical decisions under difficult situations, especially in situations dealing with Kohlberg's fourth stage. Comparison of the implementation scores of each group revealed a similar implementation pattern for the entire research group. Although the expert nurses seemed to be less influenced by stage 1, 2 and 3 considerations when implementing their ethical decisions, they seemed to be influenced by stage 4 considerations.

Discussion

Limitations

The study reported here has a number of limitations. First, the methods used in each of the studies we included in our analysis have limitations. Nurses' ethical responses to ethical dilemmas were measured indirectly through a cognitive approach, with ethical reasoning scores reflecting respondents' patterns of preference for postconventional arguments in ethical decisions and implementation scores representing the degree to which the respondents consider their decisions to be influenced by situational pressures. Nevertheless, the validation process strongly suggests that the measures developed constitute valuable indicators for ethical behaviour. Another limitation concerns the number and nature of dilemmas in the EBT. In the literature, it has been pointed out that ethical behaviour is, to a certain degree, situation-dependent (Rest 1976). More research is needed to determine

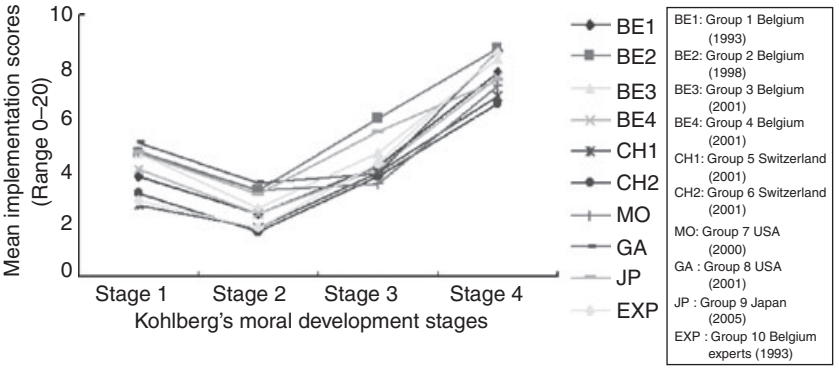

Figure 4 Individual implementation scores for each situation that epitomizes Kohlberg's moral development stage.

whether the use of more or other dilemmas would permit a more differentiated conclusion about nurses' ethical practice. Additionally, although the validity and reliability of the EBT were thoroughly evaluated, mainly by multivariate analysis, and found to be satisfactory for the Dutch version of the EBT (Dierckx de Casterlé *et al.* 1997), the validity and reliability of the French, English, German and Japanese versions of the EBT require thorough evaluation.

Second, meta-analyses have limitations. Although the meta-analysis was performed on a international database, only four countries were represented and most of the data originated from Belgian samples. Moreover, the samples of registered nurses were generally selected from one regional or teaching hospital and some samples were very small, urging cautious interpretation of the findings from an international perspective.

Discussion of the results

The results of this study showed that nurses in general evaluate stage 5 statements as most important arguments in making an ethical decision. This kind of argument refers to the first stage in Kohlberg's postconventional level of moral development. To interpret these findings appropriately, the kind of measure used for ethical reasoning needs to be taken into consideration. In these studies a 'preference measure' was used. 'Preference' tasks are easier in comparison with 'comprehension' and 'spontaneous production' tasks. That is, nurses do not have to demonstrate that they understand a statement, but only have to indicate how much they like the statement. The 'preference task' furnishes the earliest signs of the respondent's acquisition of new ideas (Rest 1976). In light of the kind of measure used for ethical reasoning, our results suggest that nurses in general can be located at Kohlberg's fourth moral stage (i.e. the conventional level of moral development). Their preference for stage 5 arguments can be interpreted as taking a first step toward the postconventional level. The differences in ethical reasoning between the expert group and the other groups implicitly point to the transition from the conventional to the postconventional level of moral development, with the expert group demonstrating an ethical reasoning pattern that approaches the postconventional level.

The implementation scores support the assumption about the nurses' conventional level. According to Kohlberg's theory, we can assume that respondents who are able to reason at a postconventional level are influenced very little, if at all, by preconventional or conventional considerations when implementing their ethical decisions. Our finding that nurses have difficulties implementing their ethical decisions in more challenging situations, especially those situations with Kohlberg's fourth stage, confirms that contextual and environmental (conventional) factors tend to guide nurses in their ethical practice.

The Belgian studies conducted between 1993 and 2001 revealed the same pattern of ethical reasoning and practice, pointing to the existence of conventional practice in recent years. The Swiss, American and Japanese studies showed a similar conventional pattern of ethical responses, suggesting that conventional practice is not a specific Flemish or Belgian problem but rather is an international phenomenon in nursing.

These findings have important implications for daily nursing practice. Conformist practice excludes a critical and creative search for the best caring answer. Indeed, in line with prevailing views, relying on beliefs and conventions rather than on searching for the best guidelines or answer is characteristic of conformist practice. Conventions (such as medical prescriptions, rules and norms of a care unit, procedures and guidelines) are relevant to nursing because they provide a framework for daily practice and may save nurses' time in favour of individualization of care. However, conventions remain instruments in the search for good practice and should never be considered as an end. Conventions need to be critically evaluated in context and in terms of their contribution to patient well-being.

Perhaps much more so now than in the past, conformist practice is a barrier to creating an environment in which doing what is best for each patient is the goal. The absence of certainty, understanding and predictability is paramount in nursing (Spitzer 1998, Plsek & Greenhalgh 2001). It is obvious that, in the postmodern world, good nursing care requires more than the application of knowledge, skills and attitudes in response to isolated questions. Creativity and critical reflection, rather than guidelines or imposed thoughts, are prerequisites to finding more appropriate answers to patients' problems.

Our results help us to understand why nurses experience environmental factors as barriers to ethical practice (Ham 2004, Varcoe *et al.* 2004, Gutierrez 2005, Torjuul & Sorlie 2006). Given the growing impact of the clinical environment, and more specifically the predominance of economic and rational values in the delivery of nursing care, it is of utmost importance that nurses are capable to practise following higher ethical reasoning to bring the greatest benefit to patients. This requires that nurses have ethical maturity, as described cognitively in Kohlberg's postconventional moral level. If a patient's well-being is used as a final criterion, then a fundamental condition for high-quality care is fulfilled. The lack of postconventional reasoning and practice we observed in the data in this meta-analysis underscores the need to find ways to promote nurses' competence for ethical practice.

What is already known about this topic

- Nurses are constantly confronted with decision-making that is ethical in nature.
- In practice, as well as in the literature, there is growing concern about nurses' ethical practice.
- Nurses perceive the working environment as a barrier to ethical practice, compromising their ability to provide competent care.

What this paper adds

- Nurses tend to reason in a conformist way in daily ethical dilemmas, being guided by conventional workplace rules and norms, rather than using creativity and critical reflection.
- Nurses have difficulties implementing ethical decisions in more challenging contexts, confirming that environmental factors tend to guide them in their ethical practice.
- Nurses' conformist pattern of ethical response in daily ethical dilemmas seems to be an international phenomenon.

Conclusion

Conformist reasoning and nursing practice are important barriers to creating an environment in which doing what is best for each patient is the goal. Current concerns about nurses' ethical behaviour thus seem to be justified. The consistency in nurses' pattern of ethical reasoning and ethical practice over time and between countries indicates that nurse educators, leaders and researchers need to give high priority to the development of nurses' ethical competence. In the postmodern healthcare climate of rapid change and growing complexity, nurses will increasingly be confronted with ethical dilemmas.

Our results, therefore, urge us to find ways to promote nurses' ethical development to go beyond conventional practice to postconventional practice, a more individual patient-centred practice. Nurses should be stimulated through education and their professional environment to reflect critically and creatively on their work in relation to patients' well-being. In addition, they need to be personally and professionally empowered in order to be able to implement difficult personal ethical decisions in practice.

The limitations identified in this study should encourage researchers to conduct empirical studies that include more countries and larger samples and involve both quantitative and qualitative approaches.

Author contributions

BD was responsible for the study conception and design. BD performed the data collection. BD & KD performed the data analysis. BD, SI, HG & KD were responsible for the drafting of the manuscript. BD, SI, HG & KD made critical revisions to the paper for important intellectual content. KD provided statistical expertise. BD, SI, HG & KD provided administrative, technical or material support. BD supervised the study.

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