SPEAKING UP OR REMAINING SILENT: UNDERSTANDING
THE INFLUENCES ON NURSES WHEN
PATIENTS ARE AT RISK

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CHAPTER ONE: INTRODUCTION

Speaking up is defined as verbalizing concerns to a person in authority (Sayre et al., 2012). Nurses are often in situations where they need to speak up to protect patients, whether from unsafe practices, sloppy techniques, or when they disagree about treatment or intervention for patients. A nonnegotiable practice expectation, patient advocacy is the third of nine provisions in the American Nurses Association (ANA) Code of Ethics (ANA, 2015). Speaking up is a verbal form of patient advocacy, and therefore, an essential nursing ethical function.

Nurses' failure to speak up for patients in need of advocacy can lead to serious or severe patient harm (Sayre et al., 2012). Additionally, this silence commonly results in moral distress for nurses (Barlem et al., 2013; Corley, 2002; The Joint Commission Sentinel Events, 2013), a situation due to a conflict with their personal values. Moral distress is often manifested in physical symptoms that cannot be medically explained (Dalmolin et al., 2014).

Although not speaking up results in serious consequences for patients and nurses, the reasons nurses speak up or remain silent have not been fully investigated. When nurses speak up they are demonstrating moral courage, however moral courage encompasses many other behaviors and situations and speaking up is specific to verbal advocacy in a critical time-period. While moral courage and moral distress have been well explored in the literature, speaking up behaviors have been only marginally discussed and therefore are poorly understood. Identifying factors of silence and mitigating them is an important strategy to protect patients. Further, moral distress from not speaking up can lead to burnout for nurses and exit from the profession (Pendry, 2007).

Research that sheds light on factors of speaking up or remaining silent has been linked to identifying strategies that protect patients and nurses. In addition to being the right thing to
do, however, fiscal sustainability is more closely tied to patient outcomes than ever before. Value Based Purchasing, an element of the Affordable Care Act, imposes severe financial penalties for organizations that have preventable patient events including but not limited to procedural complications (pneumothorax, lacerations or unintended punctures, for example), and hospital acquired infections (National Provider Call, 2013). Many of these complications are the result of poor technique or simply a lack of hand washing, and they can be prevented if nurses speak up about the behavior that is placing the patient at risk.

Preventing moral distress and ultimately burnout is essential to retain nurses who can safely care for patients. This is especially important considering current workforce staffing shortages, which are the result of a decreased supply from an aging nursing workforce and an increased demand from an aging Baby Boomer population (Shoreideh et al., 2015). Although many factors contribute to nurse burnout, nurses who speak up are more likely to reduce distress and burnout and therefore may stay in the profession to care for patients.

Organizational culture is well documented as a factor in safety (DiCuccio, 2015), primarily originating from work in high reliability fields such as the airline and nuclear power plant industries (Kind, 2004). Organizational culture applies to patient safety in health care through Just Culture methodology, which determines managerial action based on intent. For example, when making a simple error, an employee is consoled, whereas knowingly disregarding safety rules would result in disciplinary action. How organizations handle significant events and what methods they employ to ensure open communication across the organization is the foundation of organizational culture as a significant element of patient safety (Boysen, 2013). For this reason, we use the terms safety culture and (strong) organizational culture interchangeably.
One factor in organizational culture is related to oppressed group theory. Nursing is considered an oppressed group because it is primarily female in a male physician dominated industry (Roberts, 2000). Oppressed group members are more likely to treat their peers poorly. This internal group behavior is a consideration within organizational cultures (Purpora, 2012) because the negative peer pressure within oppressed groups further discourages open dialogue needed for patient safety.

Another potential factor in nurses speaking up behaviors involves workforce generational differences. There has been some limited research conducted surrounding generational differences among nurses and others in the workforce (Codier et al., 2011; Desir, 2017; Sherman, 2006; Stevanin et al., 2017). Baby boomers have been described as rule followers who respect authority. In contrast, millennials are described as believing they are equal to physicians and other persons in authority (Hendricks & Cope, 2013). Although the literature that is available suggests that nurses have very different work styles and values based on their generation (Stevanin et al., 2017), it does not shed light on how those differences impact their speaking up behaviors. Where the traditional hypothesis likely would be that older nurses (with more experience) would be more comfortable speaking up than younger nurses, the generational framework suggests the opposite may in fact be the case (Hendricks & Cope, 2013). Therefore, we explored the potential generational influences in this study.

Cultural differences are identified in many studies; likely due to the recruitment of international nurses into U.S. hospitals over the last 20 plus years, and those studies address the specific barriers international nurses encounter (Liou & Cheng, 2011; Xu, 2007). Yet there is little evidence regarding how the nurses' cultural backgrounds impact speaking up behavior. For example, some cultures rarely challenge authority. Nurses from Asian cultures may avoid eye
contact and hesitate to question those in authority. Language barriers may also be a factor in why
nurses remain silent, where they are intimidated or unsure about how to best express their
concerns (Bryan, 2017; Ho & Coady, 2018).

The available literature does not offer evidence on how the three areas of organizational
culture, generational differences, and personal culture interact to influence speaking up
behaviors, a gap this work seeks to explore. Nor does the evidence suggest that speaking up
leads to affirmation of moral courage where remaining silent leads to patient harm and moral
distress for the nurse. This project is significant because 1) the interaction of these three factors
on speaking up has not been previously examined, 2) it generates a new theoretical framework
where personal culture, organizational culture, and generational differences are the primary
factors leading to moral courage affirmation and ultimately patient safety or conversely, moral
distress and potential patient harm, and 3) it can be used to develop specific strategies to address
barriers to speaking up. Addressing these barriers is essential to improve patient safety and
protect nurses from moral distress.

The following chapters include: 2) the theory synthesis proposing the speaking up
theory, 3) an integrated review of ethical dilemmas in nursing, 4) testing the theory of speaking
up, and 5 discussion and conclusions of this entire work.
CHAPTER TWO:

SPEAKING UP: FACTORS AND ISSUES IN NURSES

ADVOCATING FOR PATIENTS WHEN PATIENTS ARE IN JEOPARDY

1 Rainer, J. (2015). Speaking up: factors and issues in nurses advocating for patients when patients are in jeopardy. *Journal of Nursing Care Quality, 30*(1), 53-62
Abstract

Although speaking up to protect patients is a key ethical and moral mandate for nurses, silence still prevails in many situations. On the basis of concepts of safety culture, generational theory, personal cultural literature, advocacy theory, oppressed group theory, and moral distress theory, the author conducted a literature review and offered a new theoretical framework. The proposed theory identified primary factors of speaking up: generational, personal culture, and organizational.

Key terms: Patient Safety; Patient Advocacy; Organizational Culture; Medical Errors, Speaking up
Introduction

The Institute of Medicine (IOM) published its provocative 1999 report *To Err is Human*, and many were astounded by the assertion that possibly 100,000 people die in hospitals annually because of medical errors (IOM, 2000). Sadly, almost 10 years later the allegation is no longer shocking and the situation has not changed; the 2007 IOM report demonstrates there has been no improvement in patient safety outcomes since 1999 (IOM, 2006). In addition to being the right thing to do, maintaining patient safety and ensuring positive patient outcomes is more closely tied with fiscal sustainability than ever before. Value Based Purchasing, an element of the Affordable Care Act, imposes severe financial penalties for organizations that have preventable patient events including but not limited to procedural complications, hospital acquired infections, and readmissions (Center for Medicare and Medicaid Services, 2013).

Through research by the IOM and other patient safety agencies such as The Joint Commission (TJC), it is clear that failure to speak up and/or communicate effectively is a factor in many errors and incidents of patient harm (National Association of Healthcare Quality, 2012; TJC, 2013). According to TJC, communication issues have been 1 of the top 3 root causes of sentinel events for over 3 years (TJC, 2013). The fact that nurses fail to offer verbal advocacy for patients is concerning because: 1) there may be harm to patients if nurses remain silent; 2) nurses are in a key position to speak up for patients they care for; and 3) nursing as a profession has a strong moral and ethical imperative for patient advocacy. Further, not speaking up can lead to burnout and moral distress for nurses (Pendry, 2007). This paper offers a review of various concepts and studies related to whether or not a nurse speaks up in a given situation, and offers a new theory based on existing evidence. A theory synthesis, as described by Walker and Avant
(2011) is a method in which a complicated, interconnected theoretical framework is developed by combining smaller, simpler elements of existing evidence or concepts.

The American Nurses Association (ANA) Code of Ethics has 9 provisions and the third relates to nurses’ moral obligation to advocate for patients. This provision is separated into the following areas: 1) physical privacy, 2) confidentiality, 3) research defense, or protecting human subjects, 4) principles and review process, where the nurse ensures anyone involved in the care of the patient is skilled to do so, 5) addressing “questionable” practice, and 6) challenging impairment (ANA, 2000). In the fifth provision, nurses must speak up if aware of situations or practices that put patients at risk of harm, and that is the focus of this manuscript.

While speaking up is an important element of advocacy (Seifert, 2012) and many nurses report being witness to unsafe practices, the majority still fail to say anything (Moss & Maxfield, 2007). In a large study co-sponsored by the American Association of Critical Care Nurses (AACN) and Vital Smarts, 50% of nurses described situations that should have resulted in speaking up, and yet only 10 percent of the time did they find their voice (Moss & Maxfield, 2007). The study identified 7 situations where speaking up is essential to protect patients; where: 1) practitioners take dangerous shortcuts, 2) mistakes are witnessed, 3) caregivers are without backup or support, 4) incompetence is clear, 5) there is a lack of teamwork, 6) disrespectful or disruptive behavior happens, and 7) poor management or micromanagement is present (Moss & Maxfield, 2007).

A literature review was conducted in CINAHL, MEDLINE, and PUBMED with search terms of patient safety, communication and safety culture, international nurses and communication, generational differences and nurses, and speaking up. Additionally, in PUBMED, searches were limited to the last 5 years for moral distress, safety culture and patient
safety and communication (there were over 700 articles in the first search) and also for international nurses and communication, taking 561 sources down to a manageable 181. After eliminating secondary sources, opinion papers, studies related to non-acute care environments, speaking up other than by the nurse, and duplicates, the final count of literature reviewed was 295. Of those 295, 60 sources met the eligibility criteria, and after an additional 12 sources were excluded for lack of relevance, 48 primary sources were included in the review (see the PRISMA flow diagram, figure 1). Based on the factors identified in the aforementioned literature, a new theoretical framework was developed.

**Review of the Literature**

There is a body of literature specifically addressing nurses speaking up for patient protection, exploring importance and barriers (Bromily, 2012; Polito, 2013; Sayre et al., 2012). Sayre et al (2012) used a quasi-experimental approach to test a process designed to improve “speaking up” in situations that indicated potential patient harm. 51 nurses in the final control group and 53 in the final intervention group participated in questionnaires, watched a video by risk management where examples of not speaking up led to patient harm, and viewed the chief nurse and a physician leader discussing speaking up for patients. Discussions were then held with the nurses to discuss challenges, and an action plan was developed. Nurses also exchanged contact information to create a support system. The post-test suggested the intervention was successful; improvements in speaking up scores for the intervention group were statistically significant (Sayre et al., 2012).

In a case study, Bromiley (2012) discussed a situation where an elective procedure resulted in the death of a young woman because the anesthesia team was unable to successfully intubate her. The author reported that several persons involved believed an emergency
tracheostomy was indicated, but they remained quiet. Crew Resource Management (CRM) was identified as a strategy that may have helped the team act in this emergency. It is a technique that employs specific strategies and tools to speak up in serious, stressful situations. Bromiley (2012) also discussed the structure of power placing nurses below physicians. Based on work done in the aviation industry, Bromiley (2012) stated that in the same way airline crews are trained to speak up, healthcare professionals must also be trained.

Other researchers focusing on speaking up used a descriptive, qualitative process, conducting interviews with 33 staff and leadership nurses representing magnet and non-magnet facilities (Garon, 2012). Results indicated that speaking up is influenced by personal and organizational factors. Other issues identified included delivery of the message (whether the nurse came across as aggressive, for example). A key finding was that nurse manager attributes were an important factor in nurses speaking up.

The aforementioned literature related to speaking up supports that power, oppression, culture, communication style, leadership support, and organizational culture may be primary factors in nurses’ lack of verbal advocacy. These concepts are explored to develop a new theoretical framework identifying primary influences of speaking up for patient safety.

**Advocacy**

Patient advocacy is concerned with patient protection, as illustrated by Hanks’ sphere of nurse advocacy model where the patient is in a bubble of protection (Hanks, 2005). The primary foundation of patient advocacy literature, however, is found in the work of Curtin, Gadow, and Kohnke (Curtin, 1979; Gadow, 1980; Kohnke, 1982). Kohnke (1982) who defines advocacy as educating and providing support to patients, states the following:
It is this reluctance in making decisions for self that makes the patient so vulnerable to the decision-making process of others. A ‘we know best’ position by professionals, combined with a ‘you know best’ position by patients, compounds this (Kohnke, 1982, p. 25).

Patient advocacy literature overlaps in describing various forms of advocacy nurses provide, where speaking up is one type and assisting patients with self-determination is another. Curtin (1979) discussed advocacy in the context of humanity and compassion, and explored the issue of providing patients with information necessary for them to make an informed choice of treatment. Gadow’s work focused primarily on the dying, a population that has clear needs in regards to self-determination (Gadow, 1980). Gadow also discussed the risk of healthcare workers acting in a “parent-like” role that inhibits patients’ right to speak for themselves (Gadow, 1980) which is a concern addressed by Kohnke (1982) as well. Kubsch et al (2004) identified multiple types of advocacy in their work, where self-determination is one type. Lastly, Bu and Jezewski (2007) developed a mid-range theory of patient advocacy, and discussed the 3 main elements of advocacy as 1) protecting patients’ rights to self-determination, 2) protecting patients, and 3) championing social justice in healthcare. The researchers stated that advocacy is situation based, and identified that advocacy lacks a common definition in the profession (Bu & Jezewski, 2007).

Several sources primarily address the advocacy role of nurses related to speaking up where patients cannot speak for themselves (Bu & Jezewski, 2007; Garon, 2012; Kubsch et al., 2004; Negarandeh et al., 2008; Sayre et al., 2012; Snowball, 1996). Two of these researchers (Sayre, 2012; Garon, 2012) have already been discussed, but a third source, Negarandeh and colleagues (2008) conducted grounded theory research on Iranian nurses. The researchers conducted interviews with 24 nurses, identifying 5 major areas with regards to advocating. One of the 5 was protecting and representing, which is the area that applies to speaking up. The
researchers recommended development of international definitions of advocacy and improved educational programs (Negarandeh et al., 2008)

Kubsch et al. (2004) addressed speak up advocacy in a correlational study of 52 nurses. There was a positive correlation between higher substitutive advocacy (speaking up for those who cannot speak for themselves) and moral stage development. Snowball (1996) addressed speak up advocacy in a qualitative study that explored the perspective of 15 nurses. Snowball’s theoretical framework presented advocacy as reactive or proactive, over either a current or a future issue, and further identified influences of change as patient, nurse, or organization. Snowball drew on Curtin’s (1979) humanity concept and stated nurses’ self-identity, personal security, and personal accountability are valuable factors in their ability to advocate as needed (Snowball, 1996).

There are studies that explore other aspects of patient advocacy. One of these is by Schmidt et al. (2010) who employed grounded theory to describe how nurses “watch over their patients during a shift” (Schmidt et al., 2010, p. 400) in the hospital setting. Fifteen nurses were interviewed themes that emerged were double-checking, being on top of things, being nearby, acting on information, and protecting (Schmidt et al., 2010). The authors developed a theoretical framework where the first 4 elements lead to action. Taking action is the speaking up phase of the model. Other researchers that explore this protective advocacy are Jacobson et al. (2010) who use the term “vigilance.”

According to the sources discussed here, advocacy research addresses patients’ right of self-determination and the need to speak for patients who cannot speak for themselves, but also includes elements of watching over patients. There are many ways in which nurses advocate for patients, but speaking up remains a key factor in patient safety. Education, support, and training
may provide assistance with equipping nurses with tools to help them find their voice as needed for patients.

**Oppressed group theory**

Oppressed group theory may provide a partial explanation for why nurses do not speak up for patients in situations where they should (DeMarco et al., 2008; Pendry, 2007; Priede-Kalnins, 1995; Roberts, 2000). DeMarco et al. (2008) developed a scale for evaluating nurse perceptions. The researchers found that education and religion had no bearing on feelings of being oppressed. Older nurses generally perceived they were less oppressed than younger generations. This may be partially due to generational differences indicating older nurses respect authority, where the respect for authority may cause older nurses to not feel oppressed, because they see the medical profession as rightfully in a position of authority over them.

Roberts (2000) compared nurses to other oppressed groups such as persons of occupied nations. An element of the oppressed is that there are rewards for those who maintain the present balance of power, which undermines attempts at self-determination by the masses. This can be applied to nursing, where speaking up is discouraged by the majority. Instead, social pressure and medical power cause people to remain silent in times that they should not. Nurses are described as having little self-worth and frequently demonstrating covert aggression similar to other oppressed groups (Roberts, 2000).

According to these sources, generational differences are a moderator to feelings of oppression which impacts nurses’ ability to speak up. Other elements related to oppressed group theory that apply relate to power structure, medical power, and nurses’ lack of self-esteem.
Generational differences

Researchers have explored the differences between age groups, and how those differences impact the nursing workforce (Codier et al., 2011; Hahn, 2011; Hendricks & Cope, 2013; Sherman, 2006; Wolfe et al., 2010). As a point of reference, veterans are considered to be born prior to 1946, baby boomers between 1946 and 1964, generation X between 1965 and 1979, and millennials between 1980 and 2000 (Hendricks & Cope, 2013). Where Codier et al. (2011) focused on emotional intelligence in the context of differences in generations and nurse capacity to care, Hendricks and Cope (2013) as well as Hahn (2011) primarily explored management of nurses representing various generations.

Hendricks and Cope (2013) put generational differences in the context of what it means to nursing leadership at the unit level. In a literature review, the researchers described the different generations in the workplace. Veterans are the most likely to respect authority. Generation X is at ease with uncertainty more than other groups, while millennials are considered to appreciate teamwork. A question that arises is whether comfort with ambiguity leads generation X nurses to remain silent or simply be less morally conflicted in situations that would cause other age groups moral distress. Another question is whether millennials are more likely to speak up than generation X nurses because they see themselves as equals with physicians and others. Younger nurses may be more comfortable expressing opinions than older nurses, regardless of experience level, which could impact speaking up for patients. For the nurse manager, the researchers stress the importance of understanding the differences in communication, commitment, and value of compensation (Hendricks & Cope, 2013). Hahn (2011) describes the generational differences in much the same way, focusing on strategies for managing the generations at work. Hahn’s work varies from Hendricks and Cope’s in the
discussion of morality. Veterans follow rules and defer to authority, but millennials tend to feel a moral obligation to do the right thing (Hahn, 2011). This may be another factor that encourages the younger generation to speak up.

On the basis of the generational literature, there is support that older nurses are less likely to speak up than younger nurses due to a different perspective of respecting authority, as well as younger nurses’ view of professional equality with other disciplines. Because this is counter-intuitive to the perception that more experienced nurses are more likely to speak up, this evidence should be further explored.

Organizational/safety evidence

d’Agincourt-Canning et al. (2011) addressed the risk to safety that occurs with disruptive behavior. The literature offers extensive evidence that organizational culture plays a significant role in patient safety and contributes to whether or not nurses speak up for patient safety (Kohnke, 1982). In fact, communication is a key element in all organizations and a significant factor in the health of an organization (Bagnasco et al., 2012; Blegen et al., 2010; Lyndon et al., 2011). Organizations that exhibit behaviors of blame and shame discourage speaking up and inhibit safety (Barnsteiner & Disch, 2012).

Ohrn et al. (2011) evaluated a patient safety culture looking at clinical outcomes of infections, patient safety, and other measures after implementation of a “Patient Safety Dialogue,” involving an improvement methodology of data reporting and regular meetings. Over 5 years, two-thirds of 50 hospital departments in 3 hospitals improved their culture, indicating the intervention was effective to significantly increase safety scores in those departments. The researchers stated that leadership and participation/support of the program may have hindered the improvement in safety culture in some areas. In other research, Goh et
al. (2013) conducted a review to aid in development of a theoretical framework to improve safety. The model of Goh and colleagues is consistent with the findings of Ohrn et al., (2011) in that these researchers also stressed that organizational learning and teamwork/collaboration are key elements to produce a safety culture.

In another study, researchers conducted roughly 3500 staff surveys and reviewed 9800 medical records in 62 emergency rooms across 20 states to find medical errors in myocardial infarction, asthma, and joint dislocation patients (Camargo et al., 2012). They found mistakes were quite frequent, and the perception of a safety culture had no bearing on occurrence of errors. Of note, however, the researchers identified that near miss identification and prevention was linked to the degree of safety culture perceived and reported by staff (Camargo et al., 2012). This is significant because the identification of near misses is important to avoid harm and redesign processes before errors reach patients (Jeffs et al., 2012).

There is a plethora of literature exploring aviation and/or nuclear power safety. Practices in these industries can provide a framework that can be applied to healthcare to improve safety by decreasing variation and encouraging positive communication methods (Melnyk, 2012; Singer et al., 2010). Crew Resource Management (CRM), one communication method, addresses not just communication and assertiveness training, but also how to manage exhaustion, distractions, and how to conduct team building exercises (Sculli et al., 2013). There are several versions of communication frameworks in the literature that specifically aim to improve patient safety (Blegen et al., 2010; Compton et al., 2012; Figueroa et al., 2013; Johnson & Kimsey, 2012; Singer et al., 2010).

Organizational and safety culture literature support the idea that creating a culture that rewards speaking up is important to improve patient safety. Whether reporting errors, reporting
near misses, or speaking up in a critical moment to protect a patient, organizational culture is an important influence on speaking up behavior. Further, organizations that adopt formal methods of speaking up, such as CRM communication training, likely have stronger cultures of safety than those that provide only lip service to patient safety.

**Cultural differences**

Nurses’ insufficient English language proficiency impedes speaking up (Liou & Cheng, 2011; Shen et al., 2012; Xu, 2007). Liou and Cheng (2011) used a phenomenology case study approach to understand the challenges for a nurse of Taiwanese background practicing in the United States. The physician she phoned asked to speak to another nurse who spoke fluent English. This intimidation acted as a barrier to advocating for patients, because the nurse was reluctant to call a physician to clarify orders or report changes in patient condition (Liou & Cheng, 2011).

Xu (2007) has done extensive work on cultural differences and experiences. In a meta-synthesis of Asian nurses working in the U.S, the researcher found 14 studies where language difficulties were a large issue. “The communication difficulties came from unfamiliar accents, usage of slang, idioms, jargon, abbreviations, recorded shift reports, and idiosyncratic physicians’ handwriting.” (Xu, 2007, p. 251). The researcher also discussed a situation where a nurse was too frightened to ask questions. Lack of seeking clarification is a significant risk factor for patient harm. Shen et al. (2012) focused on interventions to decrease language barriers, specifically a communication course intervention for international nurses. Linguistic errors were significantly reduced in the 32 participants of the experimental group post intervention, compared to the 29 participants of the comparison group. The findings suggested that targeted education can be helpful to decrease communication errors.
For international nurses, barriers to speaking up relate primarily to communication challenges, language barriers, and intimidation by domestic medical staff. Further work to evaluate strategies around education and addressing intimidation would be helpful to empower this nurses’ group.

**Moral distress**

The concepts reviewed are the primary factors that influence nurses speaking up as needed to protect patients. The lack of speaking up, especially in situations that result in patient harm, can lead to moral distress. In situations where nurses feel powerless, moral distress occurs for the nurse. Moral distress is associated with burnout, compassion fatigue, and sadly, exiting the profession. (Corley, 2002; Ganz & Berkovitz, 2011; Houghtaling, 2012; Wilson et al., 2013).

In offering a theory of moral distress, Corley (2002) suggested that nurses do not act due to time constraints, lack of support, medical power, policy, and/or legal issues. Corley provides a strong contribution to the literature through the development of this theoretical framework because it demonstrates that action (i.e. speaking up) reinforces moral courage while non-action leads to moral distress.

Another study explored moral distress of ICU and step down nurses through a descriptive study. Using the Corley tool, researchers evaluated nurses reports of frequency and seriousness of moral distress experienced. Although reporting very low levels of moral distress in the survey responses, comments in the questionnaires suggested differently. Of the 2 groups, ICU nurses reported more issues related to physician relations, which is not surprising because ICU nurses work closely with physicians in the unit (Wilson et al., 2013). In the context of the surgical nurse, Ganz and Berkovitz (2011) explored nurses’ perception of moral distress, patient care quality, and ethical issues. In general, nurses were content with quality of care, but if there were
more ethical concerns to address, there was a negative shift in caring for patients and care quality was adversely affected (Ganz & Berkovitz, 2011).

Barlem et al. (2013) conducted interviews with nurses in Brazil to explore how they handled distressing situations. Silence and avoidance were common strategies employed by the 14 nurses interviewed. On the basis of these findings, the researchers offered a theoretical framework for “taking care of self or other” and “denial of self or other” leading to rejection of self with associated behaviors, shame of the self, or acceptance (Barlem et al., 2013). This model offers specific outcomes for silence or speaking up, which are self-neglect or patient-neglect. Barlem et al. (2013) suggest that moral distress should be primarily avoided, but secondly recognized and quickly addressed for the benefit of nurses and patients alike.

Moral distress literature contributes to this current theory synthesis because it ties moral distress to action or non-action and explores the consequences of moral distress. One consequence, silence caused by moral distress, which may be originally caused by the failure to speak up, could potentially create a continued cycle of silence that may result in harm to patients.

**Theory Synthesis**

The concepts of organizational culture (including oppression and various communication techniques), personal culture and language barriers, generational differences, moral distress theory and moral courage were explored for their relationship to each other. These concepts were combined into “blocks” as defined by Walker and Avant (Figure 2). These “blocks” are the foundation for a new theory: if faced with critical situations, there are 3 primary factors that influence whether nurses speak up. These factors are organizational culture, personal culture, and generational differences. Further, failure to speak up leads to moral distress and patient harm while speaking up affirms nurses’ moral courage (Figure 3).
Conclusions

The foundation of the proposed theoretical framework lies in previous work of generational, cultural, and organizational differences (to include oppressed group theory and safety culture literature), moral distress, speaking up and patient advocacy. From the literature, it is clear that nurses speaking up or choosing silence when patients are in need of advocacy and protection is multifactorial. The theoretical framework offered here seeks to define those primary factors and provide structure to explain the influences nurses face in these situations through the technique of theory synthesis. By identifying these influences, researchers can address them to improve nurses’ empowerment and ability to take action.

There are many implications for the reader regarding speaking up or remaining silent; providing an environment where nurses find their voice is of utmost importance to nurse leaders. Furthermore, evidence clearly demonstrates that lack of communication is a key element in patient harm. Some initial recommendations for leaders include: 1) talking to staff frequently about speaking up, 2) reviewing chain of command policies so that nurses know their options if facing resistance to their objections, 3) role playing activities, 4) story sharing of situations where speaking up protected patients or remaining silent was a factor in patient harm, and 5) providing clear support for clinical staff in all serious events. It is not uncommon to neglect the caregiver, which is a tragic additional outcome in a serious preventable event.

For non-leadership readers, the significance in understanding factors of speaking up is essential to mitigate the negative forces of speaking up. Increasing awareness of personal culture, organizational culture, and generational differences can improve identification of strategies to counter these negative forces and improve speaking up behaviors. Furthermore,
celebrating moments of speaking up, and recognizing peers who find their voice can strengthen the culture and further encourage the desired speaking up behaviors.

Being able to use their voice to protect patients is a key element of nurses’ role and a clear ethical mandate. The failure to speak up to protect patients will ultimately erode the trust the public currently has with the nursing profession. Currently the most trusted of professions (ANA, 2013), nurses must advocate for patients, or the connection between remaining silent and the continued high rates of errors and patient harm will destroy that trust. Finding ways to help nurses use their voice has enormous implications for patient safety, and understanding barriers to speaking up and addressing those barriers is imperative to protect our nurses and our patients.
CHAPTER THREE:

ETHICAL DILEMMAS IN NURSING: AN INTEGRATIVE REVIEW

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Abstract

Aims: To identify themes and gaps in the literature to stimulate researchers to develop strategies to guide decision-making among clinical nurses faced with ethical dilemmas.

Background: The concept of ethical dilemmas has been well explored in nursing because of the frequency of ethical dilemmas in practice and the toll these dilemmas can take on nurses. Although ethical dilemmas are prevalent in nursing practice, frequently leading to moral distress, there is little guidance in the literature to help nurses resolve them.

Design: This paper is an integrative review of published research from 2000 to 2017.

Methods: The keywords ethics, ethical dilemmas and nurs* were searched in CINAHL, PubMed, OVID, and SCOPUS. Exclusion criteria were sources not available in English, not in acute care, and without an available abstract. Seventy-two studies were screened; 35 were retained. Garrard’s matrix was utilized to analyze and synthesize the studies.

Results: Ethical dilemmas arose from end-of-life issues, conflict with physicians or families, patient privacy concerns, and organizational constraints. Differences were found in study location, and yet international research confirms that ethical dilemmas are universally prevalent and must be addressed globally to protect patients and nurses.

Conclusions: This review offers an analysis of the available evidence regarding ethical dilemmas in acute care, identifying themes, limitations, and gaps in the literature. The gaps in quantitative intervention work, U.S. paucity of research, and lack of comparisons across practice settings/nursing roles must be addressed. Further exploration is warranted in the relationship between ethical dilemmas and moral distress, the significance patient physical appearance plays on nurse determination of futility, and strategies for pain management and honesty.
Relevance to Nursing Practice: Understanding and addressing gaps in research is essential to develop strategies to help nurses resolve ethical dilemmas and to avoid moral distress and burnout.

*Keywords:* nursing ethics, professional burnout, terminal care
Introduction

An important characteristic of a profession is the existence of defined standards of ethical behavior. For nursing, principles of ethical behavior are found in the ANA Code of Ethics for Nurses, which has been recently updated (ANA, 2015). The ANA ethical provisions above are derived from the four primary principles of bioethics: autonomy, beneficence, non-maleficansce, and justice (Seaman & Erlen, 2013). Within these provisions, nurses frequently struggle with ethical decisions where various principles may conflict. Nurses need strategies to address these conflicts.

Background

In healthcare situations, ethical principles are often competing priorities, which creates a dilemma. For example, patients may have religious beliefs that prevent them from seeking life-sustaining treatment (autonomy). In this instance, nurses might struggle with the principle of autonomy versus the principle of doing no harm (non-maleficence) or providing benefit (beneficence). Another ethical dilemma may be when privacy (autonomy) conflicts with safety concerns (beneficence) for a suicidal teenager. Also, dignity and protection may have equal and opposing desirability in patient care where restraints may be indicated to maintain life-sustaining treatment. Ethical dilemmas occur frequently in nursing practice and present multiple challenges.

In addition to the conflict created by opposing ethical principles, there can also be conflict between different ethical traditions. Deontology judges the quality of ethical decisions based on adhering to rules, where Teleological ethics evaluates the decision based on the outcome (Illingworth & Parnet, 2006), frequently referred to as “the end justifies the means.” Utilitarianism is a sub-type of teleological ethics where the greatest good for the most people is
the best possible outcome (Illingworth & Parnet, 2006). International spread of emerging infectious diseases is a very current example of applying the utilitarian ethical view. If more people benefit overall by abandoning a community in need of help (e.g. due to a high risk of an epidemic spread of disease) then the ethical course of action from a utilitarian perspective is to deny care to those in need.

Another ethical tradition is virtue ethics. According to Voet (2011), where deontology is associated with the duty to act and teleology is associated with the most benefit to the most people, virtue ethics is primarily concerned with the individual’s character as the fundamental component of ethical reasoning while making decisions. Virtue ethics often comes into play when there are no existing guidelines to steer/drive/guide decisions and decision makers rely strictly on their own values. This type of ethical tradition is particularly relevant in healthcare where the decision-maker is usually a physician, who is in a position of authority. When nurses disagree with physicians’ clinical decisions, this is a source of ethical conflict or dilemma under virtue ethics because the nurse is not the person making decisions, but the person who executes on those decisions. However, virtue ethics also directly applies to nurses when they lack external guidance on tough decisions or choices.

Ethics should not be confused with morality; an ethical dilemma is distinct from a moral dilemma. Ethical decision-making requires choosing between two equally good or poor choices. Moral decision making is influenced by personal and/or religious beliefs (ANA, 2015), whereas ethical principles that guide decisions are not necessarily moral principles. The Code of Ethics for Nursing (ANA, 2015) makes a clear differentiation between morality and ethics, where morality is related to individual or personal beliefs and values, and ethics defines right and wrong by an external source or code of behavior.
The principles discussed above illustrate that resolving ethical dilemmas is complex and requires an understanding of ethical principles to guide the decision-making process. The problem, however, is that although ethical dilemmas are prevalent in nursing practice and frequently lead to moral distress (Huffman & Rittenmeyer, 2012; Sauerland et al., 2014) there is little guidance in the literature to help nurses resolve these dilemmas. The purpose of this integrative review was to identify themes and gaps in what is known about handling ethical dilemmas in clinical nursing practice. The hope is to stimulate researchers to develop strategies to guide decision-making among nurses handling ethical dilemmas in clinical practice.

Methods

Utilizing the 12-step search strategy proposed by Kable, Pick and Maslin-Prothero (2012), ethics, ethical dilemma, and nurs* were searched as key terms in CINAHL, PubMed, Ovid, and Scopus with an initial return of over 13,000 sources. Exclusion criteria were studies not available in English, conducted in non-acute care settings or in niche specialties, and without an available abstract. Because of the strong evidence of the causes of ethical dilemmas in neonatal care due to the plethora of available evidence, neonatal studies were also excluded. The remaining studies exceeded 250, and because ethical dilemmas reflect societal advances and issues changing over time, studies were narrowed further to include the years 2000 to the present to capture the most current ethical dilemmas. The remaining 72 studies were read by one single reviewer who reviewed them for quality and relevance. Of those, 39 were eliminated for lack of relevance to the topic (for example, not involving RNs, secondary sources/reviews, or meeting exclusion criteria), leaving 33. Two studies were added from citations found in reference lists, for a final number of 35 studies that met the criteria for this review (See Prisma Figure 4). Garrard’s (2014) matrix method was utilized to analyze and synthesize the studies that were
included. The evidence matrix included 10 topics: author alphabetically, year of publication, study aim, design, location, sample description, sample size, findings, limitations, and level of evidence (See table 1 for the evidence matrix). Seven key themes were identified across all studies by categorizing similar data. Studies were further rated for quality based on Melynk and Fineout-Overholt’s (2015) levels of evidence.

Results

The research designs of the 35 studies incorporated were quantitative ($n=11$), qualitative ($n=20$), mixed methods designs ($n=3$), and 1 meta-analysis. Studies were conducted in the U.S. ($n=9$), Europe ($n=10$), Asia ($n=6$), South America ($n=3$), Australia ($n=2$), Canada ($n=2$), and the Middle East ($n=5$). Several studies were conducted in multiple countries ($n=4$). Settings included critical care, ambulatory, mental health, and acute care (oncology, surgical, and neuroscience).

Some researchers did not specifically aim to explore ethical dilemmas, although findings were very relevant to ethical dilemmas. For example, some researchers addressed whistleblowing and the issues surrounding why nurses would whistle-blow when faced with poor practice (Ahern & McDonald, 2002; Jackson et al., 2010). A few researchers were primarily concerned with moral distress (Barlem et al., 2013; Choe, Kang, & Park, 2015; Lutzen et al., 2003; Shorideh, Ashktorab, & Yaghmaei, 2012; Wadenstein et al., 2008), although the causes of moral distress were often due to an ethical dilemma or a negative patient outcome.

Overall, the studies demonstrated moderate to strong evidence. When evaluating the level of evidence in the quantitative studies, the strongest evidence based on Melnyk and Fineout-Overholt (2015) evidence hierarchy was the meta-analysis by de Casterele et al. (2008) with a sample of 1592. Next in strength of level of evidence as well as the largest sample sizes
are Pang et al. (2003), Ferrell et al. (2001), Kinoshita (2007). Other level three studies with smaller samples are Ahern and McDonald (2002), Barlem et al. (2012), Chui et al. (2009), Cooper et al. (2004), Ersoy and Goz (2001), Ganz and Berkovitz (2012), Gaudine and Thorne (2012), Ham (2004), and Konishi et al. (2002).

**End-of-Life care**

The most frequently cited ethical dilemmas were related to end-of-life issues and this prevalence of end-of-life issues is not surprising given that technological advances continue to extend life. The issues cited included communication about prognosis, inadequate palliation, questions of potential healing, and futility (Blasszauer & Palfi, 2005; Blondal & Halldorsdottir, 2009; DeWolf-Bosek, 2009; de Carvalho & Lunardi, 2009; Chiu et al., 2009; Eriksson et al., 2014; Fernandes & Moreira, 2013; Harris, 2002; Jackson et al., 2010; Kinoshita, 2007; Pavlish et al., 2012; Shorideh et al., 2012; Silen, Tang & Ahlstrom, 2009; Wadensten et al., 2008). Nurses are frequently confronted with situations where they believe dying is not being handled with sufficient attention to comfort or when further treatment is futile. In one study, researchers mentioned that emergency care was given because end-of-life discussions had not happened prior to the emergent threat to life (Pavlish et al., 2012). A few researchers specifically discussed the distressing appearance of the dying patient related to changes in skin or fluid shifts. Descriptors such as “rotting” and “already dead” were verbalized in these qualitative studies (Harris, 2002; Kinoshita, 2007; Melia, 2001), where the physical decay of patients was a key element in nurses’ ethical distress and further evidence of the ethical dilemma the nurses faced when providing end-of-life care. A common theme for nurses was that they generally accepted the dying process before physicians, who may consider palliation or hospice care a failure on their part (Blasszauer & Palfi, 2005; Chaves & Massarollo, 2009; Chiu et al., 209; Eriksson et
al., 2014; Jackson et al., 2010; Pavlish et al., 2012; Wadensten et al., 2008). In an exemplar in Melia’s work a nurse stated, “I sort of get the feeling that often it’s the nursing staff who will reach the conclusion quicker than the medical staff that enough is enough.” (Melia, 2001, p. 712).

**Physician conflicts**

Conflict regarding end of life ties closely with ethical dilemmas created by physician issues. Cited in half of the studies, physician issues encompassed the lack of authority of the nurse, conflict over patient treatment plans, lack of teamwork, and the nurses’ inability to advocate for their patients (Ahern & McDonald, 2002; Barlem et al., 2013; Blondal & Halldordottir, 2009; Chavez & Massarollo, 2009; Eriksson et al., 2014; Fernandes & Moreira, 2013; Harris, 2002; Jackson et al., 2010; Kinoshita, 2007; Silen et al., 2009; Silen et al., 2008; Wadensten et al., 2008). Although nurses’ conflict with physicians frequently related to over-treating at end of life, other sources of angst included concerns regarding physician competency, physician communication, changes in treatment plan with rotating physician coverage, and concerns of under-treatment of illness (Blasszauer & Palfi, 2005; Blondal & Halldorsdottir, 2009; DeWolf-Bosek, 2009; de Carvalho & Lunardi, 2009; Chaves & Massarollo, 2009; Chiu et al., 2009; Eriksson et al., 2014; Ersoy & Goz, 2001; Ferrell et al., 2001; Jackson et al., 2010; Kinoshita, 2007; Konishi, Davis & Alba, 2002; Melia, 2001; Pavlish et al., 2012; Silen et al., 2009; Wadensten et al., 2008).

Patient or family autonomy may be in conflict with preventing suffering if the patient or family desire to continue futile care causes suffering and lack of dignity in the process. Regarding pain, some nurses discussed drug-seeking behaviors or questioned the veracity of
patients’ reports of pain. Struggles to control pain in drug seekers were also verbalized as an ethical dilemma (Blondal & Halldorsdottir, 2009).

**Organizational constraints**

Another recurrent theme was related to organizational constraints (Ahern & McDonald, 2002; Barlem et al., 2013; Blondal & Halldordottir, 2009; DeWolf-Bosek, 2009; de Carvalho & Lunardi, 2009; Cooper et al., 2004; Ganz & Berkovitz, 2012; Gaudine & Thorne, 2012; Jackson et al., 2010; Pavlish et al., 2012; Silen et al, 2009; Silen et al., 2008; Wadensten et al., 2008). For example, staffing shortages that did not allow nurses to give the best care often led to ethical dilemmas as nurses tried to determine what they could omit or which patients needed the most care. This is referred to as rationing or missed care (Balls et al., 2014).

Other organizational issues included negative cultures that discouraged or punished nurses who spoke up for patient safety and patient rights (Ahern & McDonald, 2002; Barlem et al., 2013; DeWolf-Bosek, 2009; Chaves & Massarollo, 2009). In one international study, researchers found that patients’ ability to pay was a factor in access to care (Wadensten et al., 2008). In that study, nurses reported ethical dilemmas when patients were denied care due to poverty. (Although not reported in the U.S. literature, it can certainly be argued that ability to pay is also a factor in access to care in the States). This lack of access was attributed to organizational or cultural barriers (Silen et al., 2009; Wadensten et al., 2008).

**Family conflicts**

Families of patients also created ethical dilemmas for nurses (DeWolf-Bosek, 2009; Chaves & Massarollo, 2009; Choe et al., 2015; Fernandes & Moreira, 2013; Kinoshita, 2007; Pavlish et al., 2012; Rejeh et al., 2009; Silen et al., 2009; Silen et al., 2008). Some researchers reported this as conflict with the healthcare team in regard to the best treatment plan (Chaves &
Massarollo, 2009). For example, some families may want aggressive treatment when the healthcare team recommends hospice; other families refuse intubation for a patient who should easily wean from mechanical ventilation once the acute issue is resolved. Some researchers reported that families were unrealistic regarding prognosis or in denial about their loved ones’ end-of-life status (Chaves & Massarollo, 2009; Kinoshita, 2007; Silen et al., 2008). Sometimes families were inappropriate or hostile to nursing staff, resulting in conflict in how to care for them and their patients (Choe et al., 2015; Silen et al., 2009). Other researchers reported that family needs frequently conflicted with those of the organization (Rejeh et al., 2009). For example, ethical dilemmas arose when patients were not the decision-makers (Kinoshita, 2007) or when the family’s need to be present was physically challenging to the nursing staff providing critical care (Chaves & Massarollo, 2009).

**Privacy and dignity**

Patient privacy and dignity were also identified as a cause of dilemmas. A simple example would be when a feeble or impulsive patient wants to be alone in the bathroom and the nurse recognizes the risk that if she leaves the bathroom the patient will likely fall. Although wanting to provide patients with privacy and dignity, the nurse also recognizes the risk of injury (and therefore suffering) if she leaves the patient unattended. Autonomy, suffering, and dignity are all potential elements of end of life care but were reported by many researchers as separate issues leading to ethical dilemmas and, as a result, moral distress (Chiu et al., 2009; Fernandes & Moreira, 2013; Illingworth & Parnet, 2006; Kinoshita, 2007; Silen et al., 2009).

**Other identified themes**

Of the studies reviewed here, not all of the researchers aimed to identify situations that led to ethical dilemmas for nurses. Some focused on nurses’ responses to ethical dilemmas or
their thoughts related to ethical dilemmas. Several researchers sought to understand what led nurses to speak up (whistle-blowing) to protect patients (Ahern & McDonald, 2002; Jackson et al., 2010; Shapira-Lishchinsky, 2009). Ahern and McDonald found that whistleblowers had a less traditional view of authority than those who remained silent; that is, whistleblowers did not automatically defer to persons in positions of authority (Ahern & McDonald, 2002). Jackson et al. (2010) found a relationship between whistleblowing behaviors and organizational culture where the nurses were employed; stronger safety cultures encouraged speaking-up behaviors. de Casterle et al. (2008) sought to understand how nurses act when faced with ethical dilemmas. They identified the development of ethical reasoning as an influencing factor where nurses rank on a continuum of mature ethical thought. More ethically mature nurses made better decisions when faced with ethical dilemmas. Ersoy and Goz (2001) were primarily concerned with ethical sensitivity (defined as awareness of ethical situations). They found that more experienced nurses valued veracity and patient autonomy and exhibited higher levels of ethical sensitivity overall than their less experienced peers. In contrast, Ham (2004) found that nursing students were more advanced in what the researcher called principled thinking than experienced nurses.

**Cultural parallels and dissonance**

Several researchers examined ethical dilemmas in nursing in several different countries and most identified parallels between the various international settings. However, researchers in Hungary (Blasszauer & Palfi, 2005), Israel (Ganz & Berkovitz, 2012), and Iran (Rejeh et al., 2009), discussed findings largely different from U.S. nursing experiences. For example, the Iranian researchers (Rejeh et al., 2009) discussed ethical issues such as giving placebos or diluting pain medication. Similarly, the Hungarian researchers (Blasszauer & Palfi, 2005) reported instances of gross nursing negligence that would not be tolerated in the heavily
regulated and publicly reported U.S. environment. Despite these differences, there are many parallels between international and domestic studies included in the review. For example, to be discussed more fully later in this manuscript, the concept of truth telling was identified in studies across countries and practice settings (n=7). Further, despite their differences, the international researchers demonstrate that ethical dilemmas are an international as well as domestic nursing issue and must be addressed globally to protect nurses and patients. Researchers specifically compared ethical situations and dilemmas in different countries. Pang et al. (2003) studied a sample of 1243 nurses from three countries (U.S., China, and Japan). The U.S. sample of nurses were older, more of them were in leadership roles, and there were more men in the sample than in the Chinese and Japanese samples. This may have influenced the results, where U.S. participants were overall more principle-based in ethical decision making, in contrast to the Chinese virtue-based and Japanese sense of responsibility-based decision-making. Silen et al. (2008) compared ethical dilemmas of nurses in Sweden and in China. Primarily female, with a 10-year mean age difference between the two groups (Swedish nurses were older), both groups reported the most significant dilemmas were workload related. The Chinese also reported lack of experience and conflicts with families, Swedish nurses reported end-of-life issues and physician conflicts as the next most significant source of ethical dilemmas. Lastly, in a qualitative study, Wadensten et al. (2008) found that Swedish nurses worried more about life sustaining treatment, whereas Chinese nurses reported dilemmas related to patients’ ability to pay as a factor in access to care. Both groups reported having little authority and regular conflicts with physicians.

Looking at just the American studies, ethical issues included the inability to provide quality care related to many constraints (whether physician related, conflict with families over
goals of care, or organizational lack of resources; Cooper et al., 2004; Ferrell et al., 2001; Pavlish et al., 2012; Ulrich et al., 2010), not meeting patient desires/rights (Cooper et al., 2004; Ulrich et al., 2010), poor communication or lack of communication/honesty (Cooper et al., 2004; Ferrell et al., 2001; McLennon et al., 2013; Pavlish et al., 2012), family conflicts (Cooper et al., 2004; Ferrell et al., 2001), end of life or pain management concerns (Cooper et al., 2004; Ferrell et al., 2001; McLennon et al., 2013; Pavlish et al., 2012; Ulrich et al., 2010).

**Terminology confusion and inconsistency**

The studies reviewed demonstrated inconsistent use of terminology. Ethical dilemmas were described as challenges, issues, problems, conflicts, and concerns (Cooper et al., 2004; Ersoy & Goz, 2001; Langeland & Sorlie, 2011; Pavlish et al., 2012; Silen et al., 2008; Ulrich et al., 2010). Although these terms have slightly different meaning and suggest various levels of intensity, they were used interchangeably in the literature. The concept of ambivalence in relation to ethical dilemmas was introduced but not clearly defined (Choe et al., 2015). If ambivalence is defined as being torn between two poor choices, it is actually an ethical dilemma (Chaves & Massarollo, 2009). Ambivalence may also be over two good choices, which is a very different issue. Researchers used the terms of ethical dilemma (a situation) and moral distress (a feeling) interchangeably (Choe et al., 2015). Gaudine and Thorne (2012) describe ethical conflict as “when there are value differences between individuals and the values espoused by organizations, typically manifested through the actions of the organizations’ administrators” (Gaudine & Thorne, 2012, p. 727). Traditionally however, an ethical dilemma is when there are two equally good or poor choices (someone does not know what to do). A morally distressing situation is when someone knows what action should be taken to protect a patient, but organizational constraints prohibit speaking up (Calleja-Sordo et al., 2015; Repenshek, 2009).
One Swedish research team’s (Eriksson et al., 2014) sample was primarily composed of male nurses but the researchers did not have a clear understanding of hospice versus palliation. This was evident by utilization of the terms end of life and palliation interchangeably. Palliation is symptom control that can happen at any stage of an illness, not just at end-of-life/hospice stages (Wang et al., 2016). This is important because palliation and hospice underutilization are key issues in ethical dilemmas around end-of-life and because it provides further evidence of the inconsistent terminology found in these studies.

**Discussion**

Although a few researchers specifically identified power struggles with physicians or organizational leadership as a cause of ethical dilemmas (Blasszauer & Palfi, 2005; Blondal & Halldorsdottir, 2009; Choe et al., 2015; Melia, 2001), nurses’ lack of authority with physicians (over goals of treatment) and hospital leaders (regarding staffing or resources) emerge as a broader problem. Power struggles blanket the smaller themes of end-of-life care dissention, physician incompetence, lack of communication, conflict over goals of care, and organizational constraints. While many researchers (Ahern & McDonald, 2002; Barlem et al., 2013; Blondal & Halldorsdottir, 2009; Chaves & Massarollo, 2009; Eriksson et al., 2014; Fernandes & Moreira, 2013; Ferrell et al., 2001; Harris, 2002; Jackson et al., 2010; Kinoshita, 2007; Silen et al., 2009; Silen et al., 2008; Wadensten et al., 2008) argue that these power struggles with physicians were the cause of ethical dilemmas for nurses, one might argue that rather than creating an ethical dilemma, these power struggles actually create moral distress. That is, nurses do not experience confusion over what is the right thing, they become distressed when faced with barriers to doing the right thing. For example, when nurses are torn between poor choices of following physician orders or challenging them, an ethical dilemma would occur when nurses do
not know the right thing to do or are torn by duty to the patient vs. duty to the medical staff.

Knowing the right thing to do but being impeded from doing the right thing is, in fact, the definition of moral distress (Corley, 2002). Moral distress is generally more closely tied to organizational constraints or end-of-life issues than with physician conflict because they are impeded from doing what they know is right. And yet, it is logical that an ethical dilemma can lead to moral distress, suggesting that the definition of moral distress is too narrow as it does not allow for distress from poor choices or distress from dissatisfaction with the alternatives. In fact, Kalvemark et al. (2004) defined moral distress as any stress that is “related to an ethical dilemma” (Kalvemark in Choe et al., 2015, p. 1685). This is a distinction that perhaps should be further explored with additional study.

Congruent with this problem regarding the relationship between ethical dilemmas and moral distress, Paley (2004) and Repenshek (2009) caution that moral distress is misused when referring to physician relationships, staffing issues, and resource shortages. The moral distress concept “has been used by some nursing researchers to support a discourse of ‘whining’ about nursing issues of medical oppression” (Vanderheide et al., 2013, p. 107). While Vanderheide et al. specifically contend that working conditions are not a factor in ethical dilemmas, the counterargument from the work reviewed here is that lack of sufficient resources does cause the ethical dilemma of how to distribute care (Barlem et al., 2013; Cooper et al., 2004; Gaudine & Thorne, 2012; Ulrich et al., 2010). Rationing or missed care (Ball et al., 2014) has been only moderately explored in the U.S. literature. The reason for this is likely multifactorial including, perhaps a taboo subject in the U.S., general denial of the issue, a litigious culture, or other factors. As missed care is recognized as a real and present danger to quality nursing care and
positive patient outcomes the connection to ethical dilemmas in work environments is unmistakable.

Another theme that emerges from the literature and can be broadly applied to the subthemes of family conflict, end of life, and physician issues, is lack of honesty or truth telling (Barlem et al., 2012; Blasszauer & Palfi, 2005; Blondal & Halldorsdottir, 2009; Chiu et al., 2009; Choe et al., 2015; de Carvalho & Lunardi, 2009; Eriksson et al., 2014; Ersoy & Goz, 2001; Fernandez & Moreira, 2012; Ferrell et al., 2001; Kinoshita, 2007; Konishi et al., 2002; Melia, 2001; Pavlish et al., 2012; Shapira-Lishchinsky, 2009; Shorideh et al., 2012; Silen et al., 2008; Ulrich et al., 2010; Wadensten et al., 2008). The flavors of truth telling reported in the studies vary from vanilla to dark chocolate: lies of omission or giving incomplete information (McLennon et al., 2012), dishonesty about a prognosis due to physician pressures or the conflict with wanting to give hope (Pavlish et al., 2012), failure to disclose (Rejeh et al., 2009), and failure to report (Shapira-Lishchinsky, 2009). Pavlish et al. (2012) shed light on both the complexity and the nuance of shades of honesty in identifying the concepts of speaking up, around, and sideways. Their sample included educators, nurse practitioners, and administrators in addition to bedside nurses, demonstrating that truth telling is not just an issue for front line nursing staff. This construct of truth telling was found in both U.S. and international settings and is alarming when we consider that, at least in the U.S., nursing is still considered the most ethical profession (Brenan, 2017).

Related to end of life, the issue of patient appearance emerged (Harris, 2002; Kinoshita, 2007), and generated the following question: Are patients’ deteriorating appearances a factor in nursing’s determination of futility? Futile care is a common source of ethical dilemmas for nurses who want to ease end-of-life suffering. Is it that the patient already looks dead that causes
distress or is the nurse’s distress from distaste of caring for what appears to be a rotting body? This concept should be further explored as to how the physical appearance of patients factor into the futility determined by nurses caring for those patients at the end of life.

It is worth noting that the majority of the studies were conducted in international settings. In general, the non-U.S. nurse participants were younger with less years of clinical experience and were more likely to be women than the U.S. participants (de Casterle et al., 2008; Pang et al., 2003). Counting mixed methods in both qualitative and quantitative categories, of the 15 quantitative studies, only six were in U.S. settings; and for the 23 qualitative studies, only three were conducted in the U.S., a mere 25%. Also, when looking at studies that were conducted in only the U.S. and not a combination of domestic and international settings, the count shrinks to seven. This suggests that ethical dilemmas are better acknowledged in non-U.S. nursing environments and should be further studied in U.S. settings.

Related to both end of life and honesty, pain issues and pain management emerged (Blasszauer & Palfi, 2005; Blondal & Halldorsdottir, 2009; Chaves & Massarollo, 2009; de Calvalho & Lunardi, 2009; Ferrell et al., 2001; Rejeh et al., 2009). While there is no question that end of life pain should be aggressively treated, the discussion by Rejeh et al. (2009) regarding diluting medication or giving placebos due to scarcity, is in stark contrast to the current U.S. opiate crisis, one of the most significant government agendas because of the prevalence as well as mortality associated with opiate overdose (Bartolone, 2018; National Institute on Drug Abuse, 2018).

**Limitations**

It is of note that there is more qualitative research in this review than quantitative. It can be argued that more qualitative work is appropriate because ethical dilemmas are the nurses’
experiences and stories, stories that need to be told. However, the lack of quantitative work speaks to the lack of interventional studies, which are necessary to provide strategies to address ethical dilemmas in the workplace. In the qualitative studies, there are clearly limitations. DeWolf-Bosek (2009) asked open ended questions of 17 nurses in acute and ambulatory care. Without collecting demographics, it is unclear if the participants had a larger presence in either practice setting, which is an important missing element to put the findings in proper context. Further, several qualitative researchers did not explain their recruitment strategies or address saturation (Chaves & Massarollo, 2009; de Carvalho & Lunardi, 2009; Eriksson et al., 2014; Shapira-Lishchinsky, 2009), another limitation of the qualitative work.

The limitations of the quantitative studies include the usual threats to validity, including self-selection bias (Ahern & McDonald, 2002; Chiu et al., 2009; Ersoy & Goz, 2001; Guadine & Thorne, 2012), moderate or low power (Ahern & McDonald, 2002; Ganz & Berkovitz, 2012), heterogeneity of subjects or homogeneity (Blondal & Halldorsdottir, 2009; de Casterle et al., 2008; DeWolf-Bosek, 2009; Ersoy & Goz, 2001). For an example of heterogeneity, Blondal & Halldorsdottir’s sample ranged from nurses with 2 to 30 years of experience, and for demographics, Ersoy and Goz (2001) did not address gender.

Gaps and potential strategies

A gap identified relates to the paucity of U.S. studies. It is possible that U.S. work is focused on practice areas not included in this review (such as neonatal ICU), but clearly there is less U.S. work in general acute care practice settings than in the international nursing research community. Men, as usual in the female dominated nursing profession, are underrepresented in the studies reviewed here. Do men in nursing believe they encounter the same number and severity of ethical dilemmas as their female counterparts? Further, the similarities and
differences between nurse educators or nurse leaders and staff are inadequately explored in these studies and addressed in only a few (Cooper et al., 2004; Konishi et al., 2002; Shorideh et al., 2012). Are these differences in reported ethical dilemmas related to role, experience level, or education? This question was not adequately answered as Ham (2004) reported student nurses had higher levels of principled thinking, and yet Ersoy and Goz (2001) reported more experienced nurses had a higher regard for truth and patient autonomy.

Another gap identified in this review is the lack of interventional studies to identify strategies that nurses can employ to resolve ethical dilemmas. Specifically for end of life issues, researchers’ lack of discussion regarding ethics committees or consults suggests under-utilization of such resources which may provide support to nursing staff. Another potential strategy for organizations, not explored in this literature, is use of rounds that are designed to provide clinical staff with a forum to discuss ethically distressing situations (Schwartz Center for Compassionate Healthcare, 2017). Founded in the mid 1990’s by a forty-year-old patient dying from advanced lung cancer only days before he died, the Schwartz Center in Boston, Massachusetts, seeks to keep compassion and kindness in healthcare by providing a place for healthcare workers to share their feelings and experiences with complex and ethically challenging clinical situations.

One strategy to assist nurses in resolving physician issues or organizational constraints include strengthening the organizational culture and ensuring a strong chain of command. There must be structure and organizational support or nurses will not feel safe in reporting ethical issues. Nurses need tools to effectively address organizational constraints and conflict with families that are resulting in dilemmas, distress, and ultimately burnout. Examples of these tools are implementation and testing of a user friendly and robust anonymous event reporting system, instituting a complaint hotline, ensuring a non-punitive culture with supporting policies,
maintaining a strong ethics committee, providing nurses with pastoral care support, and/or maintaining an internal grievance process. Although organizations are required to have these things in place due to regulatory requirements, whether they are utilized must also be evaluated as a reflection of the strength of the organizational culture. These tools require training, resources, and support.

Although many of the researchers identified power struggles or unequal power as contributors to ethical dilemmas for nurses, they do not suggest how increased power would help nurses determine priorities or resolve the dilemmas (Pavlish et al., 2012). Interventions specific to nurse authority need to be explored and tested. Potential strategies would include use of scripting (providing verbiage to nurses to guide them through tough conversations), crucial confrontations training (Patterson, 2012), role playing using the chain of command, reviewing chain of command procedures, and training/policies/support for reporting uncivil or bullying behaviors.

Lastly, although this review focused on acute and critical care settings, ethical dilemmas are experienced in any and all nursing practice settings. While DeWolf-Bosek (2009) studied acute care and ambulatory, there is a clear lack of research comparing different practice settings.

Conclusions

This review offers an analysis of the available evidence regarding ethical dilemmas in acute care, identifying both themes, limitations, and gaps in the literature. Clearly, the gaps in interventional work, paucity of U.S. research, inadequate quantitative evidence, and comparisons across practice settings and nursing roles need to be addressed. Other needs identified in this review are for further exploration of the relationship between ethical dilemmas and moral
distress, the significance physical appearance of a patient plays on nurse determination of
futility, and interventional work around pain management and honesty or truth telling.

Further, terminology needs to be more tightly defined as there is confusion over morality,
ethics, stress, and distress. The concept of ambivalence and nursing ethics need further clarity,
as does the use of ethical dilemmas versus ethical conflicts or concerns, or even moral distress.

**Relevance to Clinical Practice**

End-of-life issues, the predominant cause of dilemmas found in this review, are ever
increasing as life-sustaining technology increases. The future of the profession is dependent
upon recognition and action to address ethical dilemmas in the workplace to prevent burnout.
Future researchers should focus on developing and testing strategies to help nurses identify and
resolve these dilemmas in collaboration with organizations and other practice disciplines.
CHAPTER FOUR:

TESTING A THEORY OF SPEAKING UP IN NURSING
Abstract

Objective: The purpose of this study was to understand speaking up behavior among RNs.

Background: Speaking up is the use of one’s voice to share information or alert those in authority of one's concerns about patients, and is primarily influenced by organizational culture, personal culture, and workforce generation. Failure to speak up can lead to moral distress; speaking up can lead to moral courage.

Methods: A cross-sectional electronic survey was distributed to several thousand RNs resulting in 303 surveys providing usable data.

Results: We found that organizational culture was a strong predictor of speaking-up behaviors, and that speaking up partially mediated the relationship between organizational culture and moral distress, but not between organizational culture and moral courage. Workforce generation or personal culture did not explain nurses using their voice ($U=3217, z=1.54, p=.124, r=.12$).

Conclusions: The strong role of organizational culture supports the efforts toward healthy work environments. Because not speaking up is related to moral distress, efforts must be escalated to ensure nurses are empowered to use their voices.
Introduction

The changing American workforce is anticipated to result in 500,000 RNs retiring or leaving the profession by 2022 (ANA, 2016) resulting in the need for an additional 1.1 million new RNs to avoid a shortage (Bureau of Labor Statistics, 2013). RNs leave the profession prematurely because of high physical demands and burnout (Mazurenko et al., 2015). One cause of burnout is moral distress (Epstein & Delgado, 2010; Fumis et al., 2017; Shorideh et al., 2015) a term coined over 30 years ago (Jameton, 1984) resulting from situations where RNs know the right thing to do, but organizational constraints (e.g., lack of managerial support, punitive cultures; Hamric & Blackhall, 2007) create barriers to speaking up. Failure to speak up, where speaking up is defined as using one’s voice to share information or alert those in authority (Detert & Edmondson, 2005), can contribute to patient harm (Sayre et al., 2012). Conversely, when RNs speak up, they are demonstrating moral courage, which strengthens organizational culture and enhances patient safety (Dinndorf-Hogenson, 2015). Rainer’s theory (2015) suggests that speaking up is primarily influenced by organizational culture (strong vs. weak safety culture), workforce generation (millennials vs. baby boomers), and personal culture (US vs. international; Rainer, 2015).

Moral courage and distress have been well explored; however, there is little evidence of their relationship with speaking-up behaviors. To address this gap, the purpose of this study was to understand speaking up behavior among RNs. Accordingly, our aim and hypotheses (H) were the following:

Aim: Test the model that organizational culture, workforce generation, and personal culture influence speaking up behavior, moral courage and moral distress.
H1) RNs who report working in organizations with strong safety cultures will be more likely to speak up than those who report working in weak safety cultures.

H2) Millennials (1977-1995) will be more likely to speak up than baby boomers (1946-1964).

H3) American-born RNs will be more likely to speak up than internationally-born RNs (raised outside of the U.S. and/or whose first language is not English).

H4) Speaking-up behavior will be positively related to moral courage, and

H5) Speaking up behavior will be negatively related to moral distress.

**Background/Theoretical Framework**

Organizational culture is well documented as a factor in safety, primarily originating from work in high reliability fields such as aviation and nuclear power (Day et al., 2018). Although multifactorial, two major influences on healthcare organizational culture are how errors are handled and the fact that nursing employees are considered an oppressed group (Boysen, 2013; Purpora 2012). How organizations handle adverse events and the methods employed to ensure open communication is the foundation of an organizational culture that values patient safety (Boysen, 2013; Chassin & Loeb, 2013). Thus, one way to ensure open communication is through Just Culture methods and communication strategies (Frankel et al., 2006). In a Just Culture, managerial action is based on staff intent (Boysen, 2013). For example, if a nurse knowingly disregards policies or safety measures, the manager’s response is very different than if the nurse simply made an unintentional mistake. A nurse might be consoled for a simple unintentional error. In contrast, if a nurse knowingly disregarded a safety policy, they might be formally counseled (Boysen, 2013). Just Culture is divergent from historical
organizational methods which punished people for making any kind of mistake and therefore impeded individuals desire to report safety concerns.

The other major influence on organizational culture is nursing’s position as an oppressed group (primarily female in a male physician dominated industry; Purpora et al., 2012). This authority gradient, where physicians have more power than RNs, obstructs communication which further impairs patient safety (Crosby & Croskerry, 2004). Powerful authority gradients are an important element of poor organizational cultures (Schwappach et al., 2018; Siewert et al., 2018) because they stifle open communication.

Another possible barrier to open communication may lie in generational differences, which have been understudied in regards to the nursing workforce (Codier et al., 2011; Desir, 2017; Stevanin et al., 2017). Baby boomers (born 1946-1964) have been described as rule followers who respect authority. Millennials (born 1977-1995) are described as believing they are equal to those in authority (Hendricks & Cope, 2013). The traditional hypothesis might be that more experienced RNs would be more comfortable speaking up than less experienced RNs, yet a hypothesis based on the generational framework would suggest the opposite to be the case (Hendricks & Cope, 2013).

Personal cultural differences, likely due to the recruitment of international RNs into U.S. hospitals over the last 20+ years, have been shown to provide barriers to speaking up for international RNs (Liou & Cheng, 2011; Xu, 2007). Few researchers have studied how RNs' cultural backgrounds impact speaking-up behavior. People in some cultures rarely challenge authority. For RNs whose first language is not English, language barriers or unfamiliarity with U.S. idioms can create impediments to speaking up (Ho & Coady, 2018; Liou & Cheng, 2011).
Rainer (2015) posits that the above constructs, organizational culture, workforce generation, and personal culture, influence speaking up and that speaking up can lead to moral courage and failure to speak up can lead to moral distress. Thus, the purpose of this study was to begin the work of testing this framework.

Methods

Design

This study was a cross-sectional design administered via email/web link, that included demographic information and measures of workforce generation, personal culture, and organizational culture, speaking-up behavior, moral courage, and moral distress (constructs of the speaking up model).

Subjects

A convenience sample of actively practicing bedside nurses was recruited through state and national professional organizations to ensure diversity in organizational cultures, generations, and personal cultural backgrounds. Professional organizations and hospital networks were asked to send links for study participation through emails and newsletters to RN members. Organizations/networks in Texas, Florida, and Pennsylvania agreed to send links. Inclusion criteria were RNs who were educated at the BSN level or higher, working full- or part-time providing direct patient care for at least 50% of their work hours (Magnet/NDNQI criteria for bedside nursing). Because there is evidence that hospitals with more BSN nurses have better patient outcomes (Aiken et al, 2003), excluding associates degree prepared nurses provided educational homogeneity. Nurse leaders and those in non-patient care specialties were also excluded. Recruitment began on March 1st, 2018, and concluded on June 20th, 2018. There were 484 total participants in the original sample. There were 70 surveys that did not meet inclusion
criteria (57 associates degree and 13 non-bedside nurses) and another 111 surveys with large amounts of missing data that made them usable. Therefore, the final sample for analysis was 303.

**Ethical Considerations**

Saint Louis University Institutional Review Board approved a waiver of written consent because completion of the survey implied consent. Nurses’ email addresses were not connected to their survey responses in any way ensuring anonymity.

**Procedure**

A recruitment cover letter was distributed via email and newsletters inviting bedside nurses to participate and requesting nurse leaders to forward the email to their nursing staff. The email letter instructed nurses to click on an imbedded link taking them to the online, anonymous Qualtrics survey. At the end of the survey (~30 min), nurses were invited to participate in a drawing for one of 20, $100.00 gift cards by following another imbedded link that took them to a page where they could enter their email address for the gift card drawing. The link did not connect nurses’ email addresses to their survey responses. Upon study completion, 20 recipients were randomly selected for the gift cards.

**Instrumentation**

Several instruments were used to reflect the theoretical constructs of organizational culture, workforce generation, personal culture, and speaking-up behavior, moral courage, and moral distress.

To reflect the organizational culture, the Safety Attitudes Questionnaire (SAQ) was utilized. SAQ is a 32-item scale developed by Sexton and colleagues (2006) comprised of six factors measuring perceptions of teamwork climate (quality of collaboration among colleagues), safety climate (organization’s commitment to safety), job satisfaction (satisfaction with work
experience), stress recognition (recognition of how stressors affect performance), perceptions of management (approval of managerial action), and working conditions (quality of work environment and support). The SAQ has been used widely to measure organizational culture (Sexton, et al., 2006). Responses are based on a 5-point Likert scale from strongly disagree to strongly agree, plus a not applicable choice. Sexton et al. (2006) tested the SAQ factors structure on a sample of 10,800+ participants using multi-level confirmatory factor analysis. This analysis resulted in retaining items that had satisfactory model fit and a Raykov’s \( p \) coefficient of 0.90, suggesting strong reliability. The SAQ is scored by a conversion to a 100-point scale (1=0, 2=25, 3=50, 4=75, 5=100). The two subscales each have one negatively-worded item requiring reverse coding. Subscales scores are measured as the mean and range from 60.5 to 74.3. Higher scores reflect perceptions of a strong safety culture. Speaking up-behaviors were measured by the teamwork climate subscale that includes items about how well nurse input is received in the clinical area and therefore how difficult it is to speak up about a problem with patient care. This subscale also includes items that reflect how well personnel support each other and work together, including how the physicians and nurses work as a team, how disagreements are handled, and how easy it is to ask questions. For this reason we were confident that the teamwork subscale was a strong reflection of speaking-up behaviors; it specifically describes asking questions, giving input, and how difficult/easy it is to voice a concern. For this study we refer to the teamwork climate subscale as the speak-up subscale (SU) to match the constructs in our aims. In this study, the speak-up subscale had a Cronbach’s alpha of .85.

We used the safety climate subscale to measure organizational culture because the items include key elements of a safety culture, defined as “perception of a strong and proactive organizational commitment to safety” (Sexton et al., 2006). Items include “The culture in this

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unit makes it easy to learn from the errors of others”, “I know the proper channels to direct questions regarding patient safety in this clinical area”, “I am encouraged by my colleagues to report and safety concerns I may have”, and “In this clinical area, it is difficult to discuss errors.” We determined these items to strongly represent a strong organizational culture because they addressed both handling of errors and strong teams that have been identified as key elements in safety cultures and oppressed groups (Boysen, 2013; Purpora, 2012). We likewise refer to the safety climate subscale as the organizational culture subscale (Org) to match the constructs in this study the organizational culture subscale to have a Cronbach’s alpha of .86.

To measure moral courage, we used the Moral Courage Scale (MCS; Martinez et al., 2016). It was designed to measure moral courage in physicians, but is applicable to nurses. For example, “I do what is right for my patients” or “my patients and colleagues can rely on me to exemplify moral behavior” are questions that also apply to nurses. All items applied to nurses, so the instrument was used in its entirety. Psychometric analysis with 352 interns and residents revealed one factor of 9 items with an α of 0.90 supporting its reliability (Martinez et al., 2016). Items are scored on a 7-point Likert scale from strongly disagree to strongly agree; total scores range from 9 to 63; high scores reflect high moral courage.

To measure moral distress, we utilized the nursing gold standard Moral Distress Scale Revised (MDS-R; Hamric et al., 2012). The MDS-R measures frequency (0 to 4) and level of disturbance (0 to 4) with 21 items comprising 7 factors (frequency of ethical issues, moral efficacy, unit ethics communication, ethical environment, organizational ethics support, comfort speaking up about ethics issues, and frequency of moral distress). Nurses respond about their behavior to items such as, “Provide less than optimal care due to pressures from administrators or insurers to reduce costs” or “Assist a physician who, in my opinion, is providing incompetent
“Frequency and disturbance are multiplied resulting in a composite score for each item. We computed mean scores for the MDS to provide scores for the answered items to give an estimate of moral distress. The total score ranges from 0-12.7 with higher score indicating higher moral distress. The MDS-R has a Cronbach’s alpha of .89 (Hamric et al., 2012).

We measured workforce generation through the demographic question of age and personal culture through the proxy question of nursing education completed outside of the U.S.

**Data Analysis**

MDS, MCS, SU, and Org were explored for mean, SD, skew and kurtosis, inter-scale correlations, and reliabilities and compared to the literature testing their psychometric properties. All scales demonstrated a high Cronbach’s alpha (MDS=.90, MCS=.90, SU=.85, Org=.86; table 3).

The MDS was positively skewed with normally distributed residuals and the MCS was negatively skewed with a few low scoring outliers that did not significantly alter correlations, so they were included in data analyses. All other data were normally distributed.

To address the aim, to test the model exploring the factors that influence nurses speaking up, we used Spearman correlations, Mann Whitney, and multiple regression. We conducted hierarchical regression to assess the role of organizational culture and generation on speaking up. Further, we tested speaking up as a mediator between organizational culture and moral distress. We used Kenny’s (2018) 4-step mediation testing to do this.

Because so few nurses in our sample were internationally born, we were not able to include personal culture in the model.
Results

Participant Characteristics

Demographics are reported in Table 2. It is worth noting that the majority of participants were female (93%), raised in the U.S. (90%), U.S. educated (93.1%), and with English as their primary language (93%). Years in nursing ranged from 1 to 55, with a mean of 16.7 years. Thirty-two participants (9.4%) reported a number of years practicing nursing outside of the U.S. ranging from 1 to 48, with a mean of 7.8 years. Unfortunately, there were so few participants who were educated outside of the U.S. (proxy for personal culture) that we were not able to statistically analyze the hypothesis that international nurses would differ in speaking up behaviors compared to their U.S. peers (H3). It is also notable that the workforce generation across the sample was fairly evenly distributed among baby boomers, generation X, and millennials. Practice specialties included critical care, women and infants, medical-surgical, perioperative, telemetry or stepdown, psychiatry, rehabilitation, long-term care, subacute care, and clinic settings.

Regarding statistical assumptions, the subscale data had outliers, which is why we opted for Spearman’s correlation and Mann Whitney comparison testing. Regarding multiple regression, the assumptions of linearity, normal distributions, homoscedascity, multicollinearity, and lack of autocorrelation were all met.

Testing the Theoretical Model

Nurses who reported working in organizations with strong safety cultures were more likely to speak up than those who reported working in weak safety cultures ($r_s=.75, p=.000$) supporting H1 (Table 4). Contrary to what we expected (H2), generation was not related to
speaking up [boomers (Mdn=80.7) vs. millennials (Mdn=92.4), Z=-1.536, p=.124, U=3217.00. 
\(r=.05, p>05\)].

Regression demonstrated that organizational culture was a strong predictor of speaking up. Organizational culture accounted for 65% of the variance of speaking up (\(p<.000\)). The addition of generation, accounted for only an additional .3% of the variance of speaking up (\(R^2\) change=.003; table 2). Speaking up was mildly positively related to moral courage (\(r=.13, p=.025\)) and strongly negatively related to moral distress (\(r=-.45, p=.000\)) supporting H5 (See table 2). Because statistical analysis did not support the role of workforce generation on speaking up, and because the role of organizational culture was strong, we further looked at whether years of practice was a predictor of speaking up behaviors. However, analysis did not support years of experience as a predictor of speaking up; experience accounted for .4% of additional variance of speaking up after organizational culture variance was removed (Table 5).

We further tested speaking up as a mediator between organizational culture and moral courage, as well as between organizational culture and moral distress utilizing the Kenny regression methodology (2018). Upon testing the mediation model for explaining moral courage, the first step showed that the independent variable (organizational culture) was not related to moral courage (\(R^2=.004, F=1.33, p=.249\)), thus no mediation model existed to explain moral courage. With regards to the mediational model for moral distress, each variable in each step was significant suggesting that the relationship between organizational culture and moral distress was partially mediated by speaking up (tables 6 and 7).

**Discussion**

We found that organizational culture was a strong predictor of speaking up behaviors, and that speaking up partially mediated the relationship between organizational culture and
moral distress, but not between organizational culture and moral courage. This may be because in a strong safety culture (organizational culture), moral courage is not seen as courage; it is simply normal and culturally expected behavior. Based on these findings we offer a new theoretical model (figure 5) that displays the relationship between these organizational culture, speaking up, and moral distress, removing workforce generation and personal culture from the model.

Regarding workforce generation, (specifically baby boomers vs. generation X and baby boomers vs. millennials) we found no significant relationship with speaking up. We expected boomers to be less likely to speak up than younger nurses because of the traditional regard for authority that boomers have been known for, making them less likely to question physicians (Hendricks & Cope, 2013). However, our results are consistent with the work of Jobe (2014) who evaluated workforce generations for differences in a related construct, work ethic (defined as personal ideas about work), and found no significant difference between boomers and Gen X in regards to morality/ethics. Although work ethic is not the same concept as speaking up, they are related. Strong work ethic (including the factors of self-reliance, morality/ethics, hard work, leisure, work centrality, delay in gratification, and wasted time; Miller et al., 2002) is related to a tendency to speak up (Jobe, 2014). Further, the morality/ethics (belief in being just and moral) element of work ethic suggests that nurses with a high moral code/moral courage are more likely to speak up if they disagree with patient treatment (Martinez et al., 2016).

One possible explanation for our findings that there were no generational differences in speaking up is that speaking up is a personal decision and not a characteristic of a group. The willingness and ability to use one's voice to challenge authority is likely more dependent on personal experience and environment than traditional workforce characteristics. For example
may be a young nurse on a very caustic nursing unit may remain silent where an older nurse on
an open, collegial unit might consistently challenges decisions of those in authority.

While nurse characteristics of generation and personal culture were not significant
determinants of speaking up behavior, other internal factors should be explored. For example,
what is the influence of coping skills or resilience on nurses speaking up behavior? If a nurse had
a poor experience with speaking up, these internal factors might very well impact future
behavior.

Organizational culture predicted nearly 66% of the variance in speaking up which is
consistent with high reliability research that identifies organizational culture as an essential and
significant factor in patient safety (Singer et al., 2010; Melnyk, 2012). These results clearly put
the ownership, responsibility, and duty on executives to address their organizational cultural
issues and ensure a safe place for nurses to find their voice. Healthcare systems have historically
been hierarchical and top down, where physicians and executives hold all the power,
discouraging free discussion and the ability for nurses to question patients’ medical care
(Roberts, 2000). Improving health care organizational cultures can only be done by removing
the pervasive authority gradients in our healthcare systems, rewarding speaking up, and creating
transparency in safety work and error prevention (Agency for Healthcare Research and Quality,
AHRQ, 2018).

The recent literature provides additional insight as well as questions regarding
organizational culture, speaking up, and patient safety. Olds et al. (2017) studied the predictive
value of safety culture (defined by 7 items taken from the AHRQ safety culture survey including
“staff feel like mistakes are held against them,” “things fall through the cracks,” and “in this unit
we discuss ways to prevent errors from happening again”) and work environment (including
some elements of a safe organizational culture (quality, leadership, physician relations, and safe staffing). They found that one standard deviation increase in safety culture and work environment separately resulted in a statistically significant decrease in the odds of mortality. However, when analyzed in the same model, only work environment was a significant predictor of mortality. Their research casts some doubt on the connection between (strong or safe) organizational culture and patient outcomes, and yet suggests at least a partial role of organizational culture on outcomes as work environment is a smaller piece of organizational culture. Further, this is consistent with previous studies linking organizational culture to patient outcomes (Bonner et al., 2009).

Zadvinski et al. (2018), however, were not able to link adverse events to safety climate (organizational culture in our study) or teamwork climate (speaking up in our study), but did find differences in adverse events by unit type (med-surg, procedural, critical care). The researchers acknowledge that their scores did not demonstrate much variance across units which may have affected statistical analysis. Regardless, they did not find teamwork (the subscale we used to define speaking up behavior) to relate to an increase or decrease in adverse events. This suggests further study is warranted to fully understand the role of speaking up on patient outcomes.

External factors besides organizational culture should also be examined. For example, do nurses speak up more in magnet hospitals or academic centers? What is the explanation for Zadvinski and colleagues’ (2018) findings regarding patient outcomes and unit type or setting? Do nurses speak up more in critical care units where they have more communication with the medical staff than on medical-surgical floors? Is the incidence of patient adverse events related more to staffing levels than to communication? Further, what is the nurse manager role in the speaking up behaviors of front-line nurses? Olds et al. (2017) included leadership in the work
environment. They suggest that isolating leadership as a factor in patient harm may be warranted. These study findings suggest the need for future research looking at larger samples and more diverse groups.

Barriers to speaking up are well documented in the non-nursing literature yet there is limited evidence surrounding speaking up in nursing (Rainer, 2015). Thus, this study was the next logical step to understand speaking up behavior in nurses. This study was innovative because there is no evidence on how these three constructs (organizational culture, workforce generation, and personal culture) interact to influence speaking-up behaviors, a gap this study targets. Further, this study strengthens the role organizational culture plays in speaking up and demonstrates how tightly speaking up and organizational culture are related to moral distress. The role of moral distress in nurse burnout and exit from the profession is well understood (Epstein & Delgado, 2010; Fumis et al., 2017; Shorideh et al., 2014). Our results provide an additional area of focus to reduce moral distress in healthcare organizations through work on organizational cultures that ensure safety through speaking up.

There are several limitations to this study. Because our data were self-reported, there is a threat that participants might inflate their answers to look more appealing to researchers. However, given the anonymous nature, we expect this to be minimal. More importantly, however, self-selection might result in a sample that does not fully represent the population. For example, respondents may have tended to speak up more than the general bedside RN population. Evidence supporting self-selection bias in our sample is reflected by having less men and less internationally trained nurse respondents than exists in the general nursing population. Another limitation is that respondents can suffer from recall bias. We mitigated this limitation by including only nurses who currently work at the bedside where ethical dilemmas
are likely to occur. Another limitation is that cross-sectional designs are ambiguous with regard to temporal precedence in theory testing. However, given the novelty of this model, a cross-sectional design is an appropriate first step in its development. Finally, additional limitations included the use of international nursing education as a proxy for personal culture. This may have excluded nurses who were raised internationally but educated as a nurse in the U.S. This proxy variable may have excluded nurses who should have fallen into this category of international nurse based on their cultural upbringing.

The use of teamwork climate subscale as a measure for speaking up has a few limitations. Although including specific items such as “It is difficult to speak up if I perceive a problem with patient care” and “I have the support I need from other personnel to care for patients,” some of the items in the subscale reflect not personal choices, but unit norms. For example, “It is easy for personnel in this unit to ask questions,” or “Disagreements are resolved appropriately” suggest more unit dynamics and culture than personal speaking up behavior. This may decrease the generalizability of the findings and suggest a more specific speaking-up tool should be developed. However, of the available tools (SAQ, AHRQ Safety Culture Survey), we believe that this subscale most closely represented the construct we wanted to measure because it included personal items (“It is difficult to speak up if I perceive a problem”). And, although nurses may speak up initially they may fail to follow the chain of command when they receive pushback. Determinants of speaking up until heard ensure patient safety needs further exploration.

Another consideration is that, although workforce generation and years of experience did not predict speaking behavior, we did not explore speaking up in Benner’s novice to expert
theoretical framework (Benner, 2001). The levels from novice to expert may better explain speaking up and should be further explored in this context.

Lastly, we did not explore the role that nurse resilience has on speaking up and moral distress. There is evidence that resilience is an important factor, particularly with burnout (Rushton et al., 2015), which can result from moral distress. Also, for nurses with high resilience, challenging experiences with speaking up might not influence their future behavior to the degree that nurses with low resilience would be influenced. This is another possible area for research.

Conclusions

We set out to test the theory that speaking up behaviors are primarily influenced by organizational culture, workforce generation, and personal culture, and that failing to speak up leads to moral distress while speaking up leads to affirmation of moral courage (Rainer, 2015). We found a strong relationship between organizational culture and speaking up and between speaking up and moral distress. Therefore, we propose the adjusted model shown in figure 5, which demonstrates the relationship between these three factors, removing workforce generation and personal culture from the model. We know that these are important issues for healthcare and healthcare executives, particularly the nurse executive who has ownership for decreases in both poor nurse outcomes (moral distress, burnout, turnover or complete exit from the profession) as well as patient outcomes (injury, failure to rescue, serious safety events). Although there are many limitations and areas indicated for future research regarding speaking up, this study suggests that the focus of organizations must be on improving the safety culture, breaking down the authority gradients, and creating environments where nurses and others freely express their
concerns for patients. This is important because the future of nursing and the safety of patients is dependent upon it.
CHAPTER FIVE:
DISCUSSION
The concept of speaking up (also referred to as verbal advocacy or voice in nursing) is one with a limited, albeit growing, body of evidence. While the connection to patient safety is clear (Edmondson & Herman, 2012; Bromily, 2012; Sayre et al., 2012), the factors that primarily influence use of voice when patients are in jeopardy has not been previously well understood. A theory synthesis, Rainer (2015) offered a theoretical framework which suggested nurse speaking up behaviors were primarily influenced by organizational culture, personal or ethnic culture, and workforce generation. Further, speaking up may lead to affirmation of moral courage and failure to speak up to moral distress.

Although the quantitative study here did not support the concepts of workforce generation (age) as a primary factor of speaking up, it did corroborate the elements of the theoretical framework regarding the role of organizational culture and the resulting moral distress from a failure to speak up. Further, results demonstrated a weak relationship between speaking up and moral courage, which we anticipated because of the work by Kubsch et al., (2004) that correlated speaking up to moral maturity. Moral courage is closely tied to moral maturity, which consists of seven elements, including “harnessing cognitive ability and emotional resources,” (Mathieson 2003, p. 3) which are necessary for moral courage.

Ethical dilemmas are also clearly linked to speaking up and organizational culture in multiple ways. First, these dilemmas occur in many situations where nurses are unable to verbally advocate for their patients, frequently regarding conflict with physicians about the plan of care (Rainer, 2018). End-of-life futile treatment, where nurses are opposed to aggressive measures taken by the medical team, is the most common example. Second, ethical dilemmas are often created when nurses are silent because they lack authority within the organization (Rainer, 2018). For example, they can present when nurses do not speak up for fear of punishment, or in
an environment where, for example, staffing is unsafe and care must be “rationed” (Rainer, 2018). Third, ethical dilemmas have been linked to moral distress (Caram et al., 2018) because nurses sometimes face ethical dilemmas where they are unable to do what they know is right, and this is the definition of moral distress. Because these dilemmas can result in moral distress when involving constraints on doing the right thing, this suggests that they are also clearly linked to organizational culture, where poor cultures prevent nurses from doing what they know is the right thing.

There has been additional speaking up research since that initial publication (Rainer, 2015). The work by Schwappach and Gehring (2015) is a significant one; the researchers developed and conducted psychometric analysis on a speaking up tool (which is not available in English). They found that predictors of speaking up were perceptions of supportive organizations, perceived safety, and increased age, where older healthcare providers were more likely to speak up. Our work did not support the role of age, but did support the concepts of a safe organizational culture on speaking up. In another work exploring the role of age, Sparks (2012) evaluated internal empowerment across generations and found baby boomers reported higher empowerment then their younger peers. Additional work in this area should perhaps explore the Benner levels of novice to expert and how those stages of experience relate to speaking up (Benner, 2001).

In this present study, the significance of organizational culture in predicting speaking up was underestimated ($r^2=.66$). Further, regression analysis indicated that speaking up was a mediator between organizational culture and moral distress, which suggests the primary or driving theoretical concept of moral distress is not speaking up, but in fact organizational culture. Previous evidence has linked strong organizational cultures with speaking up behaviors and
patient safety. (Ginsburg et al., 2014; Sayre et al., 2012). This present study supports that prior evidence and emphasizes the influence of organizational culture on speaking up and moral distress. The construct of an organizational culture promoting open communication and safe patient care includes: 1) eliminating authority gradients, 2) creating error and adverse event transparency, 3) applying a systematic and consistent just culture approach to unanticipated patient outcomes, and 4) rewarding those who report actual and potential safety concerns (Day et al., 2015). These elements demonstrate that organizational culture is complex and multifactorial and yet because the key to speaking up lies in the organizational culture, the responsibility to ensure a strong organizational culture is on the executive leaders. Leaders must be held accountable for creating a safe environment; as opposed to blaming individuals for failure to use their voice.

In addition, silence has also been correlated with job dissatisfaction and organizational disengagement (Morrison, 2011), which layers additional evidence on the dangers of failure to speak up and the potential related ethical dilemmas. Unresolved or poorly resolved ethical dilemmas result in moral distress (Rainer, 2015, 2018). Further, moral distress, like disengagement, is associated with burnout and exit from the profession (Moss et al., 2016).

**Implications for Practice**

The implications of this work are clear: organizational leaders, and specifically nurse executives, must own and correct deficiencies in safety culture that have been linked to patient harm in previous research (Ginsburg & Bain, 2017). Historically, healthcare organizations have been blind to issues of oppressed groups and authority gradients that weaken the safety culture. (Chassin & Loeb, 2013; Roberts, 2000) Without this clear and persistent focus, nurses will remain silent and experience moral distress, leading to burnout and exit from the organization.
and possibly the profession. And even more importantly, patients will continue to face unnecessary harm, adverse outcomes, or unplanned death when organizational cultures prevent speaking up (Bonner et al., 2009; Davenport et al., 2007). The recent study by Olds et al. (2017) further supports this threat to patients from poor organizational cultures: one standard deviation increase in safety climate score correlated to a 7% decrease in odds of mortality (Olds et al., 2017). Therefore, the connection between organizational culture and nurse/patient harm are undeniable.

High reliability organization (HRO) evidence already supports strategies that strengthen organizational culture and decrease serious safety event (SSE) rates (AHRQ, 2018), such as eliminating authority gradients, providing transparency around adverse events and event reporting, and developing a strong reward system for those who speak up. And yet barriers to implementation are daunting. This is because of organizational complexity, financial constraints, and the lack of frank discussion which should be the catalyst for organizational culture change in the first place (McMillan, 2016). Tying back to high reliability, the solutions must be created by the front line people. “If nurses do not speak their truths, their knowledge and experience will not be incorporated into dominant organizational discourses. Phenomena such as organizational change will thus remain grounded in perspectives that do not reflect the realities and complexity of nurses’ work” (McMillan, 2016, p. 227). In other words, when safety strategies are designed in the board room, they are not always practical or feasible in direct patient care, and may in fact create additional risk or harm to patients. While circular, it is inescapable that nurses are hesitant to speak up in poor organizational cultures and yet it is their voice that is required in order to redesign those cultures and make them safe and strong.
Direction for Future Research

There are several implications for future research. First, the role of workforce generation in speaking up is still unclear, since our study was not able to validate previous work suggesting a difference in generation with regards to speaking up or motivators of speaking up (Schwappach & Gehring, 2015; Sparks, 2012). Second, the international nurse voice is missing in the current research. While we sought to capture that voice, we recruited too few international nurses to test if there was a difference in speaking up related to personal culture. Previous international nursing research used to develop the international nurse elements of the initial theoretical framework (Rainer, 2015) was extremely limited and therefore requires validation (Liou & Cheng, 2011; Xu, 2007). The U.S. nursing population is poorly understood in terms of speaking up behavior, and will require unique strategies to hear their voices. Third, in the manuscript regarding ethical dilemmas, we found that the ambulatory or non-acute practice settings have not been examined (Rainer, 2018). While there is extensive evidence of ethical dilemmas in critical care and neonatal settings, many nurses face ethical dilemmas in other areas of practice. As healthcare strives to move patients out of the acute environment due to rising costs and resource constraints, more nurses are working in these other practice settings than were previously. The experiences of nurses working in these settings needs to be further explored, as these nurses are increasingly faced with ethical dilemmas from, for example, the U.S. opioid crisis or the increase in violent crime and mass shootings. This suggests that ethical dilemmas and moral distress may be related more to types of work experience than to generation. Fourth, although the evidence is clear on improved organizational culture and its link to patient outcomes (Bonner et al., 2009; Davenport et al., 2007), future nursing research should focus on implementation of strategies to improve organizational culture and to reduce moral distress and burnout, such as high reliability
strategies, role playing, and other simulation methods to encourage speaking up and patient safety. Fifth, although we acknowledge evidence that links moral distress with burnout, and have touched only minimally on burnout, we recognize, like Moss et al. (2016) that there is very little research addressing strategies to decrease burnout, which is essential to keep nurses safely and compassionately caring for patients at the bedside. Lastly, although this work captured the relationships between organizational culture, speaking up, and moral distress, the lived experience of nurses is missing, and specifically whether past speaking up experience influences future speaking up behaviors. For this reason, we will conduct a qualitative analysis of nurse speaking up experiences as our next steps in understanding this phenomena.

**Conclusions**

This dissertation involved a concept synthesis from related constructs of organizational theory, oppressed group theory, speaking up, moral distress, workforce generation, and personal culture. Based on the evidence, a theoretical framework was offered, suggesting that speaking up was primarily influenced by organizational culture, personal culture, and workforce generation, and resulted in moral distress when remaining silent or affirmation of moral courage when speaking up (Rainer, 2015). In a second manuscript, we further explored the concept of ethical dilemmas through an integrated review and concluded that ethical dilemmas arise from end-of-life issues, conflict with MDs and families, and organizational constraints (Rainer, 2018). This second manuscript supported the role of organizational culture on ethical dilemmas and moral distress, and was consistent with the work in chapter 4 (manuscript three), which also demonstrated the strong role of organizational culture on speaking up for patient safety. This third manuscript tested the theoretical framework utilizing Spearman’s correlations, Mann Whitney analysis of independent groups, and both hierarchical regression and mediator
regression models. The results demonstrated the strong role of organizational culture, the (partial) mediator role of speaking up between organizational culture and moral distress, the insignificant role of workforce generation, and the small correlation between speaking up and moral courage. We offered a new theoretical framework, signifying the mediator relationship (figure 5). Additionally, gaps/areas of future research were identified as 1) the unclear role of generation on speaking up, even though it was not shown to be significant in this study, 2) the missing voice of the internationally trained RN working in the U.S., 3) exploration of ethical dilemmas in non-acute practice settings, 4) testing strategies to improve organizational culture, 5) implementation and testing of strategies to decrease burnout syndrome in nursing, and 6) providing more qualitative analysis of the speaking up experience for nurses.
Appendix A: Permissions, Journal of Nursing Care Quality

Title: Speaking Up: Factors and Issues in Nurses Advocating for Patients When Patients Are in Jeopardy
Author: Jennifer Rainer
Publication: Journal of Nursing Care Quality
Publisher: Wolters Kluwer Health, Inc.
Date: Jan 1, 2015
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Appendix B: Permissions, Journal of Clinical Nursing

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Licensed Content Date Jul 23, 2018
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## Appendix C, Tables

### Table 1: Ethical Dilemmas Evidence Table

<table>
<thead>
<tr>
<th>Author</th>
<th>YR</th>
<th>Study aim</th>
<th>Study type</th>
<th>Location</th>
<th>Sample</th>
<th>Sample size</th>
<th>Findings</th>
<th>Limitations</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahern &amp; McDonald</td>
<td>2002</td>
<td>Review thoughts of nurses who experienced an ethical dilemma</td>
<td>Quantitative cross-sectional</td>
<td>Australia</td>
<td>Mental health and acute nurses, 73% female, ages 36-50, 84% in nursing more than 10 years (half more than 16)</td>
<td>95</td>
<td>Nurses who had a higher score on patient needs over other considerations (vs. nurses with higher traditional authority respect) more likely to whistle blow, seriousness of the misconduct not different b/w groups—authors say non-whistleblowers may have interpreted the severity wrong</td>
<td>Includes mental health nurses too, lower power than desired due to 20% response rate, power 67</td>
<td>III</td>
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<tr>
<td>Barlem et al</td>
<td>2012</td>
<td>Explore moral distress in Brazil nurses</td>
<td>Quantitative cross sectional</td>
<td>Brazil, 2 hospitals</td>
<td>All of the MD was caused by ethical dilemmas, namely: 1) competency concerns, 2) unable to advocate for pt, 3) unable to advocate for terminal, 4) work conditions limiting ability to give best care, 5) not respecting pt wishes</td>
<td>247</td>
<td>Included &quot;auxiliary&quot; nurses and nursing techs—difficult to determine the voice of RN this study was not about ethical dilemmas, but all of the causes of MD presented are consistent with factors of ethical dilemmas presented in the other sources</td>
<td>III</td>
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<tr>
<td>Blasszauer &amp; Palfi</td>
<td>2005</td>
<td>Enlighten readers on the limitations of terminal care in Hungary</td>
<td>Qualitative</td>
<td>Hungary</td>
<td>76 nurses and another 250 students (nurses and other healthcare students)</td>
<td>76 plus 250</td>
<td>Related to lack of authority, patient suffering, lack of education of ethical principles (?), ethical issues with dying pts, conflict with MDs,</td>
<td>Does not explain demographics, VI writing style sometimes unclear on study findings vs. author commentary, includes non-ethical issues for nurses, states education would eliminate ethical issues where it probably would not, excuses neglectful behavior—very different culture</td>
<td>VI</td>
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<tr>
<td>Author</td>
<td>YR</td>
<td>Study aim</td>
<td>Study type</td>
<td>Location</td>
<td>Sample</td>
<td>Sample size</td>
<td>Findings</td>
<td>Limitations</td>
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<tr>
<td>Blondal &amp; Halldorsdott</td>
<td>2009</td>
<td>To explore experience of nurses who care for patients in pain</td>
<td>Qualitative</td>
<td>Iceland</td>
<td>Acute care med/surg, 2 yrs exp minimum, (range 2 to 30), mean age 41.7</td>
<td>10</td>
<td>Looked at ethics around caring for pts in pain, addicts in pain particularly stressful dilemma, fear of over sedating, concerns over honesty/med seeking, palliative pts refusing pain meds, MD gate keeper issues, poor management of pain from discontinuity, dying, time constraints</td>
<td>All female sample, exp. 2 to 30 is a huge range in a small group. Recruitment criteria unclear</td>
<td>VI</td>
</tr>
<tr>
<td>Chaves &amp; Massarollo</td>
<td>2009</td>
<td>Explore thoughts on dilemmas in terminal pts for icu nurses</td>
<td>Qualitative</td>
<td>Brazil</td>
<td>Nurses with over 4 yrs exp, general icu, 100% female, 90% post grad degree</td>
<td>10</td>
<td>Dilemmas from 1) values conflict with terminal care, 2) professional responsibility conflicts with terminal, 3) conflict with family not accepting dying, 4) difficult to accommodate family presence, 5) conflict from prolonged suffering</td>
<td>All women, 10 included to reach saturation</td>
<td>VI</td>
</tr>
<tr>
<td>Chiu et al</td>
<td>2009</td>
<td>Evaluate ethical dilemmas in terminal cancer pt care</td>
<td>Quantitative</td>
<td>Taiwan</td>
<td>MDs and oncology nurses, 67% female, 35.27 avg yrs old, 32% in oncology, 61% nurse, exp. 10.667 yrs</td>
<td>505</td>
<td>Primary dilemmas around clinical management: 1) artificial nutrition, 2) antimicrobial use, 3) palliative sedation, 4) blood, 5) opioid use, 6) steroids, and after clinical management communication with truth telling, appropriate level of care, hospice referral, and euthanasia</td>
<td>Some issues not congruent with US, cause of dilemmas not separated by discipline, but related variables were, stat analysis provided for predictive variables, but not for the causes of dilemmas. Did not share power analysis</td>
<td>III</td>
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<tr>
<td>Author</td>
<td>YR</td>
<td>Study aim</td>
<td>Study type</td>
<td>Location</td>
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<tr>
<td>de Casterle et al</td>
<td>2008</td>
<td>Report study of nurses reactions to ethical dilemmas</td>
<td>Meta-analysis</td>
<td>4 countries: Belgium (4), Switzerland (2), USA (2), Japan (1)</td>
<td>9 studies: subjects primarily female, mean ages 28-39</td>
<td>1592 nurses</td>
<td>Ethical reasoning scores varied among groups, of the six kohlberg stages, nursing importance of them similar to bell curve</td>
<td>Reported as lack of situational factors. Most included studies were prior to 2000</td>
<td>I</td>
</tr>
<tr>
<td>de Carvalho &amp; Lunardi</td>
<td>2009</td>
<td>Understand how nurses handle futile treatment</td>
<td>Qualitative</td>
<td>Brazil, 2 hospitals</td>
<td>Nurses working more than 1 year,</td>
<td>6</td>
<td>Ethical issues of prolonged suffering, potential for healing, resource use appropriately, concern for humanized care. Dignity and autonomy can still exist when death is inevitable</td>
<td>Not purely about ethical dilemmas, very little on nurse demographics, only 6 interviews</td>
<td>VI</td>
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<tr>
<td>DeWolf Bosek</td>
<td>2009</td>
<td>Explore ethical issues encountere d and evaluate decision making factors</td>
<td>Qualitative</td>
<td>USA</td>
<td>Staff nurses</td>
<td>17</td>
<td>Dilemmas related to 1) not meeting patient wishes, 2) poor communication of prognosis, 3) family conflicts, 4) fear of retribution if requesting an ethics consult. Differentiation of clinical, professional and organizational/societal ethical dilemmas</td>
<td>Inpatient and ambulatory. 2% response rate. No demographic data provided to protect participants</td>
<td>VI</td>
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<tr>
<td>Eriksson et al</td>
<td>2014</td>
<td>Explore ethical dilemmas and the consequenc es of them on dying stroke pts</td>
<td>Qualitative</td>
<td>Sweden</td>
<td>Neuro nurses and others, (therapists, MDs, and CNAs) median stroke exp. 7 yrs, 12 were men</td>
<td>13 nurses/ 41 total participants</td>
<td>Dilemmas around change in treatment plan, artificial nutrition, aggressive tx vs hospice, lack of influence with MDs, communication issues. Palliation and hospice used interchangeably.</td>
<td>Included non-nurses too. Large sample for qualitative. Findings by discipline well defined</td>
<td>VI</td>
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<tr>
<td>Fernandes and Moreira</td>
<td>2012</td>
<td>Identify ICU nurses ethical dilemmas</td>
<td>Qualitative</td>
<td>Portugal</td>
<td>ICU/7 women, 8 men, mean age 34, mean 10 yrs exp., 9 married</td>
<td>15</td>
<td>5 themes of end of life decisions, privacy, patient and family interactions, team work, and health care access, feeling marginalized</td>
<td>Clinical situations, context, and nursing individual factors lead to ethical issues. Recruitment questions</td>
<td>VI</td>
</tr>
<tr>
<td>Author</td>
<td>YR</td>
<td>Study aim</td>
<td>Study type</td>
<td>Location</td>
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<tr>
<td>Ferrell et al</td>
<td>2001</td>
<td>Evaluate beliefs on pain management - ethical dilemmas for members of American Pain Society</td>
<td>Mixed methods</td>
<td>USA</td>
<td>189 nurses, 79% aged 35-54, 85% female, 76% more than 15 yrs nursing exp, 65% more than 7 years in pain, 25% academic setting</td>
<td>1105</td>
<td>Primary dilemmas: 1) management of pain at end of life, 2) impact of managed care on pain treatment, 3) under-treatment of pain, 4) under treatment in elderly, 5) under treatment in children Qualitative findings inappropriate pain management, 2) barriers to care, 3) conflicts, 4) regulatory issues, 5) euthanasia, 6) research issues</td>
<td>Not just nurses, but results are separated by discipline, no statistical analysis.</td>
<td>VI</td>
</tr>
<tr>
<td>Ganz &amp; Berkovitz</td>
<td>2012</td>
<td>To explore ethical dilemmas, MD, and thoughts on quality with surgical nurses</td>
<td>Quantitative cross sectional</td>
<td>2 Israeli Surgical nurses, mean age 39.7, 79% staff nurses, 70% married</td>
<td>119</td>
<td>Ethical dilemmas: 1) inappropriate behavior of pt or family toward staff, 2) conflicts b/w pts and families. Power &gt; 0.8, 74% participation</td>
<td>Grouped ethical dilemmas with MD, not the same issue exactly. Some reported dilemmas may have been the duty to report the issue, not the issue itself - nurse violence toward pt for example.</td>
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<tr>
<td>Gaudine &amp; Thorne</td>
<td>2012</td>
<td>Correlate ethical conflict, stress, organizational commitment, to turnover and absences a year after</td>
<td>Quantitative longitudinal</td>
<td>Canada Acute care/nurses in 4 hospitals, mean age 39.4, mean exp. 13.3 yrs</td>
<td>410</td>
<td>Absenteeism associated with ethical conflicts, org commitment and stress; some conflict from staffing</td>
<td>Seems more the definition of MD than ethical dilemma</td>
<td>III</td>
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<tr>
<td>Author</td>
<td>YR</td>
<td>Study aim</td>
<td>Study type</td>
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<td>Harris</td>
<td>2002</td>
<td>Explore dilemmas and issues with withdraw of ECMO in adults</td>
<td>Qualitative</td>
<td>UK</td>
<td>Nurses with experience in</td>
<td>9</td>
<td>Issues were: 1) justification, 2) nurses role in decisions, 3) involvement of others in decisions. Concept of</td>
<td>Did not report demographic of participants. Met saturation. More about issues than exploring dilemmas</td>
<td>VI</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>grounded</td>
<td></td>
<td>withdraw of ECMO</td>
<td></td>
<td>appearance—&quot;rotting&quot;</td>
<td></td>
<td></td>
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<tr>
<td>Jackson et al</td>
<td>2010</td>
<td>Explore reasons behind blow the whistle and give info on the experience</td>
<td>Qualitative</td>
<td>Australia</td>
<td>Nurses who blew the whistle</td>
<td>11</td>
<td>Blew whistle b/c they couldn't &quot;advocate for pts&quot; -- a dilemma. Caused by incompetent peer, bad department</td>
<td>Blew whistle b/c they could not &quot;advocate for patients&quot; — a dilemma. Caused by incompetent peer, bad department practices, culture of silence</td>
<td>VI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Australia</td>
<td></td>
<td></td>
<td></td>
<td>practices, culture of silence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinoshita</td>
<td>2007</td>
<td>Explore ICU nurses and problems respecting end of life wishes</td>
<td>Mixed methods</td>
<td>79 Japan</td>
<td>93% female, mean age 30, mean exp. 8.6 yrs</td>
<td>1210</td>
<td>Ethical dilemmas from 1) patient wishes not known, 2) persons other than patient making decision, 3) poor info on prognosis to family, 4) conflict with ICU aggressive environment and dying needs, 5) patients expected to recover, and look terrible (characteristics of ICU end of life). Large majority of nurses felt patient wishes for end of life were not respected</td>
<td>mean age and experience less than usual US counterparts</td>
<td>VI</td>
</tr>
<tr>
<td>Langeland and Sorlie</td>
<td>2010</td>
<td>Explore ethical situations in ER</td>
<td>Qualitative</td>
<td>Norway</td>
<td>ER/mean age 40, 6-20yrs exp.</td>
<td>5</td>
<td>3 themes of vulnerability, responsibility and priorities. Used ethical dilemmas and Challenges interchangeably</td>
<td>Very small number of participants</td>
<td>VI</td>
</tr>
<tr>
<td>Author</td>
<td>YR</td>
<td>Study aim</td>
<td>Study type</td>
<td>Location</td>
<td>Sample</td>
<td>Sample size</td>
<td>Findings</td>
<td>Limitations</td>
<td></td>
</tr>
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</tr>
<tr>
<td>Lutzen et al</td>
<td>2003</td>
<td>Explore moral stress synthesize 2 qualitative studies</td>
<td>Quantitative</td>
<td>Sweden</td>
<td>2 studies</td>
<td>15/36 nurses</td>
<td>ICU study discussed issues of wanting to act, knowing something should be done: consistent with a dilemma. Moral stress definition matches moral distress/also uses moral sensitivity term consistent with MD definition</td>
<td>included a psychiatric study and an ICU study, outside of inclusion criteria</td>
<td></td>
</tr>
<tr>
<td>Melia</td>
<td>2001</td>
<td>Explore handling of ethical issues in ICU</td>
<td>Qualitative</td>
<td>Scotland</td>
<td>General ICU, pediatric ICU, cardiology, CCU, teaching hospitals</td>
<td>24 nurses</td>
<td>Caused by futility/withdraw, concern for dignity, appropriateness of care, discontinuity and change of treatment plan per MD, limbo in decisions, already dead—appearance. Argues that nursing ethics is about power struggles</td>
<td>Included nurse managers, large number of nurses included in interviews but inconsistent approach—some in groups of 2, some solo</td>
<td></td>
</tr>
<tr>
<td>Pang et al</td>
<td>2003</td>
<td>Compare ethical roles b/w American, Chinese and Japanese</td>
<td>Quantitative</td>
<td>US, China, Japan</td>
<td>Chinese 413, 68% 18-30, 99% female, 85% staff nurse/japan 52% 18-30, 96% female, 87% staff, US 61% over 41, 87% female, 88% nurses</td>
<td>1243</td>
<td>Specific issues not important per nationality differed, in importance: US do no harm, Japan and sense of responsibility highest, Chinese more virtue based, Us more principle based, Japan care based. Principles what you ought to do and virtue what ought to be—nice</td>
<td>11 point scale is not precise. Americans much older and more men, included leadership roles</td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Continued
<table>
<thead>
<tr>
<th>Author</th>
<th>YR</th>
<th>Study aim</th>
<th>Study type</th>
<th>Location</th>
<th>Sample</th>
<th>Sample size</th>
<th>Findings</th>
<th>Limitations</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejeh et al</td>
<td>2009</td>
<td>Understand ethical issues with pain management in surgical pts</td>
<td>Qualitative</td>
<td>Iran</td>
<td>24 women, 2 men, mean age 33.45, mean exp in surgery 10.6. 4 with master’s degree</td>
<td>26</td>
<td>Conflict from organizational limits, closeness to the suffering of pt, nurses “fallibility”. Can have shortages in narcotics--dilute them, not enough resources to monitor pt closely, dc in pain, ex. Scissors’ left in pt--unable to tell them the truth, issues with addiction/not believing pts, desensitization to pain, poor judgment (gave placebo for ex)</td>
<td>16 bedside nurses--also counted sups and nurse manager. Very different culture than nursing in USA.</td>
<td>VI</td>
</tr>
<tr>
<td>Shapira-Lishchinsky</td>
<td>2009</td>
<td>Evaluate ethical dilemmas in relation to nurse professional status</td>
<td>Qualitative</td>
<td>Israel</td>
<td>18 organizations, 33 women, age 25-55. 10 -40 yrs exp.</td>
<td>52 nurses</td>
<td>Autonomy vs. safety for pts, (following rules), loyalty vs reporting misconduct, keep secrets vs duty to report, process vs outcome, family needs vs organizational</td>
<td>Included populations (psych) excluded from original search criteria. Difficult to draw parallels with US</td>
<td>VI</td>
</tr>
<tr>
<td>Shorideh et al</td>
<td>2012</td>
<td>Explore moral distress in Iran</td>
<td>Qualitative</td>
<td>Iran</td>
<td>28 staff nurses and 3 educators, 67% female, mean age 38, exp. 10 yrs</td>
<td>31</td>
<td>Futility, negligence, disrespecting pt wishes,</td>
<td>Primarily concerned with MD, several causes due to ethical dilemmas</td>
<td>VI</td>
</tr>
<tr>
<td>Silen et al</td>
<td>2008</td>
<td>Evaluate stress and ethical dilemmas in neuroscience nursing</td>
<td>Qualitative</td>
<td>Sweden/university hospital,</td>
<td>Mean age 36.7, 71% married or sig other, 89% basic nursing education, median exp. 3 (range 1-41)</td>
<td>21</td>
<td>Causes workplace distress, ethical dilemmas, managing distress and ethical dilemmas, quality of nursing. Subthemes--couldn’t do job right, difficult or demanding families, issues with withdraw, helplessness with very ill pts, privacy issues--curtain separating</td>
<td>One interview only--may have had additional info with a follow-up interview design. Recruitment confidential</td>
<td>VI</td>
</tr>
<tr>
<td>Author</td>
<td>YR</td>
<td>Study aim</td>
<td>Study type</td>
<td>Location</td>
<td>Sample</td>
<td>Sample size</td>
<td>Findings</td>
<td>Limitations</td>
<td>Level of evidence</td>
</tr>
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<td>------------</td>
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<td>-----------------</td>
<td>-------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Ulrich et al 2010</td>
<td></td>
<td>Evaluate the stress and ethical issues in practice</td>
<td>Quantitative cross sectional</td>
<td>US</td>
<td>4 states, 95% female, 84% white, exp. 19.8 yrs, 18% masters prepared, mean age 45</td>
<td>422</td>
<td>Issues r/t protecting pt rights, informed consent issues, staffing, end of life. Younger nurses more stress and ethical dilemmas</td>
<td>Included non-acute settings, differences across state samples.</td>
<td>III</td>
</tr>
<tr>
<td>Wadensten et al 2008</td>
<td></td>
<td>To compare Swedish and Chinese experience with ethical dilemmas and distress in the work environment</td>
<td>Qualitative piece of mixed study</td>
<td>Sweden and China</td>
<td>Swedish mean age 37, exp. 7.7 yrs, china mean age 33, exp. 14.1, neuroscience setting</td>
<td>41</td>
<td>Ethical dilemmas for both groups conflicting views with MDS on appropriate treatment, little authority to &quot;fulfill duty and give best care&quot;, Swedish more worry over life sustaining treatment and China patient finances dictating quality of care</td>
<td>Can't tell if men were included-- some content areas not classified as ethical dilemmas actually are</td>
<td>VI</td>
</tr>
</tbody>
</table>
Table 2: Demographics

<table>
<thead>
<tr>
<th></th>
<th>FREQUENCY</th>
<th>PERCENT</th>
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<tr>
<td><strong>GENDER:</strong></td>
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<td></td>
</tr>
<tr>
<td>MALE</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>FEMALE</td>
<td>281</td>
<td>93</td>
</tr>
<tr>
<td><strong>EDUCATION:</strong></td>
<td></td>
<td></td>
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<tr>
<td>BSN</td>
<td>178</td>
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<tr>
<td>GRADUATE</td>
<td>99</td>
<td>32</td>
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<tr>
<td>DNP</td>
<td>16</td>
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<tr>
<td>PHD</td>
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<td>3.3</td>
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<tr>
<td>US RAISED</td>
<td>275</td>
<td>90</td>
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<tr>
<td>US EDUCATED</td>
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<td>93.1</td>
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<tr>
<td>ENGLISH AS A FIRST LANGUAGE</td>
<td>280</td>
<td>93</td>
</tr>
<tr>
<td><strong>GENERATION:</strong></td>
<td></td>
<td></td>
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<tr>
<td>VETERANS</td>
<td>2</td>
<td>&lt;1%</td>
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<tr>
<td>BABY BOOMERS</td>
<td>80</td>
<td>27.8</td>
</tr>
<tr>
<td>GENERATION X</td>
<td>113</td>
<td>39.2</td>
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<tr>
<td>MILLENNIALS</td>
<td>93</td>
<td>32.3</td>
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Table 3: Scale Statistics

<table>
<thead>
<tr>
<th>Scale Statistics</th>
<th>Org Culture</th>
<th>Speak-up</th>
<th>Moral Courage</th>
<th>Avg MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>302</td>
<td>303</td>
<td>302</td>
<td>295</td>
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<tr>
<td>Missing</td>
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<td>0</td>
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<td>8</td>
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<tr>
<td>Mean</td>
<td>75.0402</td>
<td>75.2475</td>
<td>89.9329</td>
<td>3.5046</td>
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<tr>
<td>Std. Error of Mean</td>
<td>1.29353</td>
<td>1.33715</td>
<td>.69973</td>
<td>.14617</td>
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<tr>
<td>Median</td>
<td>82.1429</td>
<td>83.3333</td>
<td>92.5556</td>
<td>3.0455</td>
</tr>
<tr>
<td>Mode</td>
<td>100.00</td>
<td>100.00</td>
<td>99.96</td>
<td>.00</td>
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<tr>
<td>Std. Deviation</td>
<td>22.47919</td>
<td>23.27567</td>
<td>12.15998</td>
<td>2.51051</td>
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<tr>
<td>Variance</td>
<td>505.314</td>
<td>541.757</td>
<td>147.865</td>
<td>6.303</td>
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<tr>
<td>Skewness</td>
<td>-.968</td>
<td>-1.084</td>
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<tr>
<td>Std. Error of Skewness</td>
<td>.140</td>
<td>.140</td>
<td>.140</td>
<td>.142</td>
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<tr>
<td>Kurtosis</td>
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<td>24.708</td>
<td>.521</td>
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<tr>
<td>Std. Error of Kurtosis</td>
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<td>.279</td>
<td>.280</td>
<td>.283</td>
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<tr>
<td>Range</td>
<td>89.29</td>
<td>100.00</td>
<td>98.11</td>
<td>12.73</td>
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<tr>
<td>Minimum</td>
<td>10.71</td>
<td>.00</td>
<td>1.85</td>
<td>.00</td>
</tr>
<tr>
<td>Maximum</td>
<td>100.00</td>
<td>100.00</td>
<td>99.96</td>
<td>12.73</td>
</tr>
<tr>
<td>Sum</td>
<td>22662.14</td>
<td>22800.00</td>
<td>27159.73</td>
<td>1033.85</td>
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<tr>
<td></td>
<td>Org Culture</td>
<td>Speak-up</td>
<td>Moral Courage</td>
<td>Moral Distress</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>----------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Org Culture</strong></td>
<td>Pearson</td>
<td>1</td>
<td>.809**</td>
<td>.057</td>
</tr>
<tr>
<td></td>
<td>Correlation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.000</td>
<td>.057</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td><strong>N</strong></td>
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<td>302</td>
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<td>294</td>
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<tr>
<td><strong>Speak up</strong></td>
<td>Pearson</td>
<td>.809**</td>
<td>1</td>
<td>.111</td>
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<tr>
<td></td>
<td>Correlation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.000</td>
<td>.054</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td><strong>N</strong></td>
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<td>303</td>
<td>302</td>
<td>295</td>
</tr>
<tr>
<td><strong>Moral Courage</strong></td>
<td>Pearson</td>
<td>.057</td>
<td>.111</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Correlation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.325</td>
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<td>.464</td>
<td>.464</td>
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<tr>
<td><strong>N</strong></td>
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<td>302</td>
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<tr>
<td><strong>Moral Distress</strong></td>
<td>Pearson</td>
<td>-.558**</td>
<td>-.531**</td>
<td>.043</td>
</tr>
<tr>
<td></td>
<td>Correlation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.000</td>
<td>.000</td>
<td>.464</td>
<td>.464</td>
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<tr>
<td><strong>N</strong></td>
<td>294</td>
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</table>

**. Correlation is significant at the 0.01 level (2-tailed).
### Table 5: Regression Model Summary and Coefficients/Speak up as dependent variable

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R²</th>
<th>Adj R²</th>
<th>SEE</th>
<th>R² Change</th>
<th>F Change</th>
<th>df₁</th>
<th>df₂</th>
<th>Sig. F Change</th>
<th>Durbin-Watson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Culture</td>
<td>.81</td>
<td>.66</td>
<td>.65</td>
<td>13.64</td>
<td>.66</td>
<td>568.46</td>
<td>1</td>
<td>300</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Organizational Culture</td>
<td>.81</td>
<td>.66</td>
<td>.65</td>
<td>13.62</td>
<td>.003</td>
<td>1.40</td>
<td>2</td>
<td>298</td>
<td>.248</td>
<td>2.238</td>
</tr>
<tr>
<td>Boomers-0 vs GenX,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boomers-0 vs Millenial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>95.0% CI for B</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>B</td>
<td>SE</td>
<td>Beta</td>
<td>T</td>
</tr>
<tr>
<td>Organizational Culture</td>
<td>.83</td>
<td>.04</td>
<td>.81</td>
<td>4.68</td>
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<tr>
<td>(Constant)</td>
<td>12.18</td>
<td>2.81</td>
<td>4.33</td>
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<td>.04</td>
<td>.80</td>
<td>23.25</td>
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<tr>
<td>Boomers-0 vs GenX</td>
<td>2.81</td>
<td>1.92</td>
<td>.06</td>
<td>1.47</td>
</tr>
<tr>
<td>Boomers-0 vs Millenial</td>
<td>.18</td>
<td>2.01</td>
<td>.00</td>
<td>.09</td>
</tr>
</tbody>
</table>
**Table 6. Regression coefficients for the mediation models**

<table>
<thead>
<tr>
<th>Steps for testing mediation of MDistress model</th>
<th>R</th>
<th>R²</th>
<th>Adj R²</th>
<th>SEE</th>
<th>R² Cha</th>
<th>F Cha</th>
<th>df₁</th>
<th>df₂</th>
<th>Sig. F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) IV→DV: Org Culture→M Distress</td>
<td>.57</td>
<td>.320</td>
<td>.316</td>
<td>48.65</td>
<td>.32</td>
<td>84.77</td>
<td>1</td>
<td>180</td>
<td>.000</td>
</tr>
<tr>
<td>2) IV→M: Org Culture→Speak-up</td>
<td>.81</td>
<td>.654</td>
<td>.653</td>
<td>14.04</td>
<td>.654</td>
<td>567.83</td>
<td>1</td>
<td>300</td>
<td>.000</td>
</tr>
<tr>
<td>3) IV→DV: Org Culture→M Distress</td>
<td>.57</td>
<td>.320</td>
<td>.316</td>
<td>48.65</td>
<td>.32</td>
<td>84.77</td>
<td>1</td>
<td>180</td>
<td>.000</td>
</tr>
<tr>
<td>IV &amp; M→DV: Org Cult. &amp; Speak-up→M Distress</td>
<td>.59</td>
<td>.346</td>
<td>.338</td>
<td>47.86</td>
<td>.026</td>
<td>7.001</td>
<td>1</td>
<td>179</td>
<td>.009</td>
</tr>
</tbody>
</table>

IV=independent variable, M=mediator variable, DV=dependent variable, Org Culture= M Courage...
Table 7: Unstandardized and standardized coefficients of the mediation model supporting moral distress as the dependent variable.

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>T</th>
<th>Sig.</th>
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</thead>
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<tr>
<td><strong>Model 1:</strong></td>
<td></td>
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</tr>
<tr>
<td>Org Culture</td>
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<td>-.566</td>
<td>-9.207</td>
<td>.000</td>
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<td><strong>Model 2:</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Org Culture</td>
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<td>.267</td>
<td>-.329</td>
<td>-3.050</td>
<td>.003</td>
</tr>
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<td>Speak-ip</td>
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</tbody>
</table>
Figure 1: MODIFIED PRISMA 2009 Flow Diagram, Speaking up
Figure 2: Synthesis Process
Figure 3: Speaking Up Theoretical Framework
Figure 4: MODIFIED Prisma, Ethical Dilemmas
Figure 5: Modified Theoretical Model


doi:10.1097/jnn.0000000000000049.


Huffman, D. & Rittenmeyer, L. (2012). How professional nurses working in hospital
environments experience moral distress: a systematic review. *Critical Care Nursing*, 91-100.


Miller, M., Woeher, D. & Hudspeth, N. (2002). The meaning and measurement of work ethic:


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