

**THE RELATIONSHIP OF CONSCIENCE AND ETHICAL CLIMATE AMONG  
REGISTERED NURSES IN THE ACUTE CARE ENVIRONMENT**

by

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Capella University

November 2016

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## **Abstract**

Although there has been extensive research on factors contributing to moral distress, burnout, and turnover intentions in the nursing profession, there has been limited research on the relationship of conscience and ethical climate. Both the ethical climate theory and moral distress theory were utilized to guide the implementation of this study. A predictive correlational design was utilized to determine the relationship between the variables defined as perceptions of conscience, hospital ethical climate and stress of conscience. A purposive, non-probability-based sampling of 193 registered nurses throughout the state of Louisiana was surveyed using a web-based survey instrument. The results of this study verified a significant relationship exists between perceptions of conscience and hospital climate. An additional relationship was established between hospital ethical climate and stress of conscience. There was no relationship found between nursing demographics and job characteristics, however. The use of conscience serves as an important guide for the nurse's moral agency. The findings of this study indicate that nurses view conscience as an asset and authority and perceptions of conscience contribute to the ethical climate of nursing units. Factors indicating a poor ethical climate can lead to a stress of conscience in nurses. Based on the results of this study, a caring, supportive, interdisciplinary team-based environment is important for the nurse to act with moral courage during ethically difficult patient-care situations.

## **Dedication**

To accomplish a monumental goal such as the achievement of a doctoral degree is something that happens with the love, guidance, and encouragement of several people. This work is dedicated to those who have loved me most deeply and saw in me at times a strength and ability that I did not always see in myself. It is their belief that helped me to move forward and accomplish this dream. One of these individuals is my great grandfather, Alexander Robbins. He encouraged me as a young girl to obtain as much education as I could and he promised me that he would always be with me to cheer me on. Over the years and long since he has died, I have had experiences in my life where I have been reminded many times of that precious promise. I feel him most strongly now. I dedicate this work to honor him for all that he has bestowed on me and my life as a result of his hard work, personal sacrifices and his unwavering love and faith in God. My love and gratitude for my great grandfather are eternal.

My sweet husband, Van, has been the wind beneath my wings though out this entire journey. It is his unwavering belief in me and his willingness to push me to achieve this dream that has sustained me. I consider myself blessed to be married to my best friend and soul mate. It is because of him that I wanted to stretch and achieve something better than I could have possibly imagined. I could not have completed this PhD without my one true love and I dedicate this achievement to him. I love you, Van.

Finally, I dedicate this accomplishment to each of our sons, sweet daughter-in-law and our precious grandchildren. You have inspired me and there are no earthly words to

truly describe my great love for you. Thank you for being understanding and for enduring through this journey with me. I will love you always.

## **Acknowledgments**

There are many people who have encouraged and guided me through this long and sometimes difficult journey. Without the support of my family, friends, and my committee, I would have never been able to reach this goal. For that I am eternally grateful. First, a special appreciation is extended to Dr. Julia Moore for serving as my dissertation mentor. I would not have made it without you. Your constant encouragement allowed me to finally move forward toward this goal and see the light at the end of this tunnel. To my committee members, Dr. Darleen Barnard and Dr. Jason Zerwekh, thank you for your insights and positive feedback during this process to help me obtain this PhD.

To my family, beloved parents, sweet mother-in-law and late father-in-law, Dr. Barney Kyzar, thank you for instilling me the idea of perseverance and excellence. Without your love, I would not be where I am today.

To Dr. Paula Stechschulte, thank you for gently reminding me to “get out of my own way” so this incredible journey could begin. Your friendship will never be forgotten.

To Dr. Chris Cassirer, it is hard to believe that meeting you nearly 10 years ago would change the trajectory of my education. You told me this journey would prove to a great spiritual experience for me with many lessons. You were right. Thank you so much for your mentorship.

Finally, to my friends and fellow faculty members at Northwestern State University, including Janet Darfus, Dr. Norann Planchock, Dr. Pam Simmons, Dr. Laura Aaron, and Dr. Katheryn Arterberry, thank you for being the examples I aspire to be and for your constant support, friendship and encouragement.

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## **CHAPTER 1. INTRODUCTION**

### **Introduction to the Problem**

The United States is on the verge of a major nursing shortage and the numbers may worsen through 2025 (Buerhaus, Auerbach, & Staiger, 2009; Grant, 2016). There are multiple reasons for this shortage, such as the aging of the nursing workforce, a shortage of nursing faculty and the inability of nursing schools to rapidly produce enough graduates to meet current healthcare industry demands. Another concern, however, is that many nurses are leaving the hospital environment or the profession entirely. Some studies have established that moral dilemmas are a significant factor in nurses' decisions to leave their employers or the profession altogether (American Association of Critical Care Nurses [AACN], 2008). Thus, the need for nursing and healthcare leaders to understand the implications associated with ethical issues and staff retention is critically important.

Nurses face ethical dilemmas on a daily basis and experience conflicts between their professional oath, a desire to care for the suffering, and a fiduciary duty to serve against the ever-expanding body of legal and regulatory requirements. These conflicts have become compounded further in recent years due to increasing moral dilemmas involving patient quality of life issues and deciding when, how, or if, life should be continued despite very poor prognoses (Rushton & Kurtz, 2015). Personal difficulty can occur for the nurse when honoring a patient's or family member's healthcare decisions causes internal moral or religious conflict.

Nurses often struggle with how to balance their own personal beliefs with patient-care decisions in various work environments with multiple responsibilities. Nurses are accountable to the facility that employs them, the physicians with whom they work, the

patient for whom they provide care, the families to whom they must respond, the nursing profession to which they belong, and the familial, cultural, and religious communities that shape their senses of identity (Oak, 1996). In each of these areas, it is possible for moral conflicts to arise causing the nurse to encounter multiple ethical challenges and a stress of conscience (Ahlin, Ericson-Lidman, Eriksson, Norberg, & Strandberg, 2013; Corley, 1995; Corley & Selig, 1994; Cronqvist, Theorell, Burns, & Lutzen, 2004; Glasberg, Eriksson, & Norberg, 2007; Kelly, 1998; Peter, Macfarlane, & O'Brien-Pallas, 2004). A nurse may know the correct ethical decision to choose but feel unable to act on it.

The healthcare organization's ethical climate also plays a vital role in the nurse's chosen work environment, and additional study has focused on this climate as a determinant factor for behavior (Hart, 2005; Hwang & Park, 2014; Malloy et al., 2009; Olson, 1998; Sims & Kroeck, 1994; Wimbush & Shepard, 1994). In the realm of daily patient-care activities, the nursing unit's climate can serve as the foundation for support mechanisms which nurses may utilize for coping with difficult situations and to moderate the effects of moral stress. How nurses view their work environments could determine if an ethical concern is raised among other nursing staff members and whether the situation will or will not be resolved. Moreover, the ability to address many of the dilemmas experienced can be affected by the ethical climate of the specific practice area (Borhani, Jalai, Abbaszadeh, & Haghdooost, 2014; Hart, 2005).

Nurses may attempt to reduce their exposure to personal moral conflicts based on their specialized nursing practice and/or work environments, such as choosing employment in a religiously affiliated vs. a non-religious institution. Historically,

religious-based healthcare facilities in the United States have been able to dictate the services offered to communities based on the organization's doctrinal tenets (Feder, 2005). As a result, certain procedures that would conflict with the religious teachings of the institution and/or those services which might be viewed as morally objectionable have been excluded from availability without any reprisal or consequence from state or federal regulatory agencies. Hospitals can be considered moral communities (Brownsword, 2010; Hardingham, 2004); however, the law has been more solicitous of protecting individual conscience and less protective of institutional conscience (Nelson, 2009).

Several studies have examined the effects of moral and ethical conflicts experienced by the nurse. While much of the research has largely demonstrated positive correlations between moral distress, burnout and intent to turnover/leave (Corley, 1995; Cummings, 2009; DeVillers & DeVon, 2013; Elpern, Covert, & Kleinpell, 2005; O'Connell, 2015; Whitehead, Hebertson, Hamric, Epstein, & Fisher, 2015; Wiegand & Funk, 2012), there is a gap in the nursing literature regarding the role that conscience plays in ethical decision-making by nurses in the United States. It is important to identify how the ethical climate of the hospital work-setting and the nurse's perception of conscience could affect factors that lead to a possible stress of conscience. The term 'stress of conscience' in the healthcare system relies on values and priorities that exist implicitly or explicitly, bringing into question the working environment itself (Glasberg, Eriksson, & Norberg, 2007). Little is known about what nurses, as individuals, think about conscience (Laabs, 2009), and further empirical research could determine if a simultaneous relationship of ethical climate and stress of conscience may contribute to moral distress in nurses. This study was aimed towards expanding the field of nursing

bioethics by examining the relationship between ethical climate and perceptions of conscience and stress of conscience among registered nurses working in the hospital acute-care setting within the state of Louisiana. Data was gathered through the administration of three online surveys to nurses randomly selected from across the state.

### **Background of the Study**

The implication regarding the use of conscience by health care providers, including nurses, remains an unsettled area of bioethics (Pope, 2010). In general, the rights of nurses involve human rights, civil rights, rights created by healthcare legislation, rights centered around professional ethics, and earned rights (Kangasniemi, Viitalahde, & Porkka, 2010). Currently, nurses, along with their physician colleagues, possess a right to use their consciences to voice a conscientious objection to procedures or services which they may deem as morally objectionable without fear of reprisal. Such protections exist due to the Church Amendment, also known as the “Conscience Clause,” which was passed in 1973 by the U.S. Congress (Wicclair, 2011). While conscience protection rights were initially aimed at protecting physicians and nurses who morally objected to participation in abortion services, this has been expanded over the years to include other factors of reproductive rights such as late-term abortion and stem cell research. End-of-life care issues associated with withdrawal of hydration and nutrition, euthanasia, assisted suicide/dying and the discontinuance of other technological life-saving medical treatments have also been included (Curlin, 2007; Ersek, 2005; Epstein, 2010; Lindsay, 2007).

Nurses often encounter such challenges in the hospital environment and there are many complexities which complicate decision-making. The ethical dilemmas may lead to

moral distress in the nurse (Musto, Rodney, & Vanderheide, 2015). Some researchers argue that systemic organizational changes must be made in response to the apparent rise in the levels of moral distress in the healthcare environment. Moral stress and distress outcomes, which include an exodus from the nursing profession, have received increased focus and concern among healthcare leaders (Pauly, Varcoe, & Storch, 2012). Some researchers argue that systemic organizational changes must be made in response to the apparent rise in the levels of moral distress in the healthcare environment (Hamric, 2010; Kalvemark, Hogland, Hansson, Westerholm, & Arnetz, 2004).

Examining the hospital ethical climate and the role of nursing conscience is important for healthcare leaders because an intense national debate is occurring, and the issue regarding healthcare providers' conscience rights has come under greater scrutiny (Dresser, 2005; Kane, 2009; Lindsay, 2007; Pate, 2009; Roberts, 2014; Rienzi, 2012). Leaders from both within the healthcare profession and from the greater community have called for the discontinuance of providers' conscience rights in making healthcare decisions. These decisions are based on views regarding the need for fair and equitable care (Meyers & Wood, 1996; Savelescu, 2006; Savelescu, 2007), addressing the needs of the medically indigent, and removing access barriers to care. Other challenges involving arguments against conscience rights are due to concerns about patient discrimination or a denial of women's reproductive rights. As such, conscientious objection has also been referred to as conscientious refusal (Davis, 2004; Fiala & Arthur, 2014; Little & Lyerly, 2013; Marsh, 2014; Weinstock, 2014; Wicclair, 2011). Additionally, changes in professional roles, referred to as "task shifting" or "task sharing," such as what transpires when a nurse transfers the care of a patient to another nurse due to moral objections,



have frequently not succeeded in the past. This has sometimes compromised health care quality and patient safety (Crisp & Chen, 2014; Oak, 1996).

The challenges posed by physicians and nurses refusing to provide care based on moral or religious grounds has received increased international attention in recent years (Fitzgerald & McLeod, 2014). The debate appears to be increasing in political importance, including in Canada (Downie & Nassar, 2008; Rogers & Downie, 2006), Brazil (Camargo, Guilhem, Kuhn-Lago, & Rodrigues, 2014), the United Kingdom (Deans, 2013; Jarvis, 1995; Laurance, 2007), Spain (Sanchez-Esparza, 2012), South Africa (van Bogaert, 2002) and Italy (Palma, 2012). Legal questions have also arisen due to conflicts, and the debate remains very active on how to balance the patient's rights versus the conscience rights of the healthcare provider (Pope, 2010).

Key healthcare and nursing organizations have provided some directives to guide healthcare leaders and clinicians. The Joint Commission, which provides accreditation for hospitals, outlines expectations for healthcare administrators regarding how healthcare entities deal with employees who may voice their consciences or raise objections to particular patient care actions because of ethical, moral, or religious reasons (Cady, 2008). The organization explains that a process for hospital review must exist which permits consideration for exclusion requests, and during those times where a staff member is excused from being involved in certain patient care activities, the hospital must ensure that a plan is in place to maintain the continuity of quality care (Joint Commission International, 2014).

For nursing, the American Nurses Association (ANA) is the organization which represents and provides support to all registered nurses (Blais & Hayes, 2015). The ANA

provides the Code of Ethics, last revised in 2015, to guide nurses in their ethical analysis and decisions. While the ANA does not provide a definition of conscience, it does describe the need for the nurse to maintain personal integrity and moral preservation (ANA, 2015). Conscientious objection is defined in the Code of Ethics as “the refusal to participate in some aspect of patient care on moral or religious grounds” and is noted as a duty to self (Fowler, 2015). Because of increasing moral distress related to conscience conflicts, the ANA has called upon nurse leaders to respond and work to resolve these issues to protect the integrity of the nurses (Fowler, 2015).

### **Statement of the Problem**

Studies on healthcare providers’ consciences are very limited in the literature. A few exist that examine the role of conscience involving multiple types of clinicians internationally. However, a much smaller research focus in the United States has been primarily limited to physicians’ perceptions and attitudes (Curlin, Lawrence, Chin, & Lantos, 2007; Lawrence & Curlin, 2009). Although physicians’ conscience rights have long been accepted, those of nurses are less recognized (Dickens, 2001). A search of the research literature revealed that the research on the relationship between the hospital ethical climate and the role of conscience among registered nurses was underdeveloped. Research on nursing conscience has been mostly limited to international healthcare settings in Sweden and Finland, and both inpatient and outpatient nursing personnel were sampled. Studies involving ethical climate have examined relationships between burnout, moral distress, and intent to leave in-hospital and long-term care settings in the United States (Filipova, 2009; Fogel, 2007; Hamric & Blackhall, 2007; Olson, 1995; Olson, 1998; Whitehead et al., 2015), Canada (Pauly, Varcoe, Storch, & Newton, 2009), Sweden

(Lutzen et al., 2010; Silen, Kjellstrom, Christensson, Sidenvall, & Svantesson, 2012), Finland (Numminen, Leino-Kilpi, Isoaho, & Meretoja, 2015; Suhonen, Stolt, Katajisto, Charalambous, & Olson, 2015) and South Korea (Han, 2014; Hwang & Park, 2014).

Further examination is needed to determine the differences of ethical climate in the work setting in a more generalized fashion (Malloy et al., 2009), especially as it pertains to registered nurses. Healthcare leaders play a vital role in ensuring that the ethical issues that arise reflect mutuality for those involved. The consequences of ignoring conscience or holding the belief that nurses are unable to object on the basis of conscience are critical for nurse leaders to recognize if they are to create environments that are morally supportive (Ford, Fraser, & Marck, 2010). Sustaining a positive work environment in the healthcare organization is vital to ensuring patient care quality and is necessary for nurse retention. Additional research findings explaining the interface between the hospital ethical climate and the role of nursing conscience can assist administrators in developing workplace environments suitable for the flourishing of safe places for nurses to voice ethical concerns (Ford et al., 2010).

If nurses do not believe they are safe to speak to other colleagues or a nurse manager about their troubled consciences, they may internalize their feelings which can cause additional work stress. As an example, Baker (1996) argues that nurses may decide to avoid voicing their desire to refuse a clinical procedure due to fear of peer pressure or being negatively judged. Nurses who voice their moral conscience and go further to object may be labeled troublemakers by their peers and find the work environment unbearable (Baker, 1996). Concerns related to workplace incivility and nurse bullying in the hospital environment are supported in the nursing literature (Lee, Bernstein, Lee, &

Nokes, 2014; Matt, 2012). The nursing unit can be potentially threatened by negative, non-supportive behaviors of nursing peers (Bartholomew, 2013). These actions may lead to serious consequences for the healthcare organization, as nurses who fear professional conflicts and/or experience negative peer pressure may succumb to severe work stress, delay patient care due to avoidance and disengagement, or cause a clinical error potentially resulting in patient harm (Farrell, Bobrowski, & Bobrowski, 2006; Jirapaet, Jirapaet, & Sopajaree, 2006; Longo & Hain, 2014; Rosenstein & O'Daniel, 2008; Veltman, 2007). Job dissatisfaction and ultimately job turnover may occur if nurses perceive that the ethical climate of their particular work environment compromises their primary obligation to their patients (Hart, 2005).

Due to unresolved ethical dilemmas and related workplace incivility which can cause moral distress, leaving an employer may be the only option for some nurses. Repeated violations of conscience can provoke various reactions by the affected nurse. The most dramatic responses can be the exodus from the institution altogether where the issues go unaddressed or unresolved, or a continued compromise of individual integrity (Rushton, 2013). There is increased recognition that the impact of stress of conscience and moral distress in nurses can compromise the safe clinical progression of patients and cause nurse retention problems, thus requiring a method to address the cause of the issue (Ahlin, Ericson-Lidman, Eriksson, Norberg, & Strandberg, 2013; Ericson-Lidman & Ahlin, 2015; Laabs, 2007). For those reasons, the variables of perceptions of conscience, ethical climate, and stress of conscience among registered nurses practicing in the acute care setting were important concepts to study. Current and predicted future worldwide

nurse shortages further support the need for this research (Schluter, Winch, Holzhauser, & Henderson, 2008).

### **Purpose of the Study**

The purpose of this study was to conduct a quantitative descriptive correlational investigation to examine the relationship between ethical climate and the role of conscience in registered nurses who worked in acute care hospital facilities in Louisiana. Personal characteristics included the respondent's background information (i.e., institutional information, education level, years of experience) and information about the respondent's thoughts on the ethical climate of the patient care unit using the Hospital Ethical Climate Survey [HECS] (Olson, 1995). Five dimensions are categorized in the HECS instrument to measure nurse perceptions which are inter-correlated and not considered independent (Olson, 1998). These five dimensions of relationships are peers, patients, managers, hospitals and physicians.

Conscience was measured by the Perceptions of Conscience questionnaire (PCQ) which assessed different beliefs on where nurses think conscience originates, and what its nature and functions are (Dahlqvist et al., 2007; Gustafson, Eriksson, Strandberg, & Norberg, 2010). Examining background data and information was important to this research to identify factors and characteristics that could be related to the hospital ethical climate where the nurse is employed and attitudes about the importance of conscience. The second part of this study asked respondents to identify concerns that may contribute to a stress of conscience, also referred to as a troubled conscience, by using the Stress of Conscience (SoC) questionnaire (Glasberg et al., 2006). This stress was measured by

frequency of selected stressful situations and the amount of troubled conscience the nurse experienced in each of those occurrences.

While the relationships of various types of organizational climates, including ethical climate, have been studied in multiple industries and disciplines, there is a paucity of research that addresses the relationship between ethical climate, perceptions of conscience and stress of conscience. An examination of conscience beliefs and how these beliefs may be influenced by the ethical climate of various hospital units could provide insight into differences and similarities that will add to the collective knowledge in nursing bioethics. A better understanding of the contributing factors to high levels of stress of conscience in nurses should result in improvement in nursing educational ethics programs and in specific support systems designed to aid the nurse during moral dilemmas in the work setting. The data obtained provide additional insight to nurse leaders and assist with needed methods to reduce the likelihood of nurses departing from their chosen specialty, changing employers, or leaving the profession.

### **Rationale**

Numbering in excess of 3,000,000 in the United States, nurses are the largest specialization working within the healthcare field; thus discussions concerning potential challenges to caring for patients with multiple issues, the aging population or technology advances are directly linked to nurses and the additional ethical challenges they face (Der Bedrosian, 2015). The work of nursing is first and foremost about being in the service of others. Nurses tend to be the most visible representatives of healthcare, especially in hospital settings. The process of providing patient care while supporting individual autonomy and protecting the moral preservation of the nurse is fraught with moral

complexity. In an increasingly diverse and pluralistic society, there is a need for articulation and negotiation of ethical principles within the nursing work environment. A morally supportive environment and a culture of excellence must be constructed and crafted with intentionality (Fowler, 2015).

One of the primary purposes of advancing nursing science is the development of a stronger evidence base through multiple, confirmatory strategies (Polit & Beck, 2012). Identification of interventions that are tailored to the ethical dilemmas nurses experience and methods to recognize moral distress require additional investigation. While previous studies have examined the relationship of outcomes of moral distress, a greater understanding of the root causes related to factors associated with moral intentions is necessary especially within specific organizational systems. Nurse researchers need to advance beyond the description of moral distress and test actions that counteract nurses' feelings of powerlessness (Caitlin et al., 2008).

In terms of internal capacities of the nurse, there is an opportunity to identify how the role of conscience is perceived and the resultant implications during ethical decision-making that may contribute to a troubled conscience. An understanding could provide additional scientific insights to the nursing profession, including nurse leaders, on methods to help prevent and mitigate contributory factors that negatively impact moral intent and moral courage. Nurses work both individually and collectively to construct an ethical environment and to remove barriers to its development and maintenance (Fowler, 2015).

Understanding of the work environment and organizational climate has grown globally over the past years (Olson, 1998) and additional research is needed. An

exhaustive review of the literature revealed that nursing studies on the perception of conscience have occurred internationally, but not in the United States. A significant gap in literature also exists regarding the relationship between ethical climate and stress of conscience. Therefore, empirical knowledge is required in this area to add to the important work of nursing ethics research. This study utilized a descriptive, correlational study to examine the variables of hospital ethical climate, perceptions of conscience, and stress of conscience in registered nurses in the state of Louisiana. This type of research design facilitates the identification of many interrelationships and can examine variables that have occurred or are currently occurring (Grove, Burns, & Gray, 2013). This research could illuminate nurse perceptions of the hospital ethical climate and may assist nurse leaders to develop or advocate for supportive frameworks or models that help to acknowledge and address conflicts of conscience.

### **Research Questions and Hypotheses**

These questions guided the analysis for this study:

**RQ1:** What is the overall relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses in the acute care setting?

*H1o:* There is no relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses.

*H1a:* The relationship of hospital ethical climate and perceptions of conscience will be positively related to stress of conscience among registered nurses.

**RQ2:** What is the relationship between perceptions of conscience and stress of conscience among registered nurses?



*H2o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H2a:* There is a positive, significant relationship between perceptions of conscience and stress of conscience among registered nurses.

**RQ3:** What is the relationship between perceptions of conscience and hospital ethical climate among registered nurses?

*H3o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H3a:* There is a positive, significant relationship between perceptions of climate and hospital ethical climate among registered nurses.

**RQ4:** What is the relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse?

*H4o:* There is no significant relationship between hospital ethical climate and stress of conscience among registered nurses controlling for age, gender, specialization and number of years working as a nurse.

*H4a:* There is a positive, significant relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse.

**RQ5:** How do demographic factors and job characteristics influence stress of conscience among registered nurses?

*H5o:* There is no influence of demographic factors and job characteristics on stress of conscience among registered nurses.

*H5a:* There is an influence of demographic factors and job characteristics on stress of conscience among registered nurses.

**RQ6:** How does perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographic and job characteristics?

*H6o:* There is no difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

*H6a:* There is a difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

### **Significance of the Study**

Nurses are the backbone upon which healthcare systems are built and as ethical dilemmas continue to escalate, it is important to understand the current views of nurses on the options employed to address such challenges. In the work environment, which Morrison and Furlong (2014) describe as being currently full of uncertainty and white water change, nurses may be placed at daily risk for experiencing a stress of conscience. The measure of nursing influence in the institutional environment accounts for the most significant variance in nurses' stated actions to find resolution for ethical dilemmas, with specific concerns about ethics (Penticuff & Walden, 2000). Nurses desire the knowledge and ability to balance loyalty to patients and their families, following physician orders, working on a family-centered interdisciplinary team and still follow their consciences

when the care being ordered is perceived to be detrimental to the patient (Caitlin et al., 2008) or involves the ending of life. The study's findings could significantly influence how the professional nursing community views the challenges which may be associated with acting on one's conscience as a means of moral preservation in the hospital setting. The results will offer insight into registered nurses' attitudes about factors associated with ethical climate and how this may influence a troubled conscience.

The motivation in the study lies in the fact that there are thousands of nurses who start their careers hoping to make positive change in the healthcare industry but then appear to quickly become disillusioned by the reality that confronts them. Ethical dilemmas that often occur in various hospital units can be the elephant in the room that few want to acknowledge. Unresolved value conflicts and a lack of support from other healthcare team members lead to feelings of anger, guilt and loss of integrity on the part of the nurse (Blais & Hayes, 2016). This can lead to nurse disengagement and compromise patient care and safety. Exiting from the profession may be viewed as the final option for some nurses. Therefore, the study's findings may suggest possible staff retention or nurse turnover implications to healthcare leaders.

Such knowledge comes at an important time when many organizations are striving to stabilize nurse staffing by improving retention and to decrease turnover as a workforce shortage is looming. Many researchers are projecting the registered nurse shortfall to worsen in the next two decades (Crisp & Chen, 2014; Buerhaus, Auerbach, & Staiger, 2009; Juraschek, Zhang, Ranganathan, & Lin, 2011) and the number of nurses needed due to growth and replacements will be close to 1,500,000 by 2025 (U.S. Bureau of Labor Statistics, 2013; American Association of Colleges for Nursing, 2014). Nursing

turnover affects healthcare organizations in profound ways including fiscally with increased costs, perceptions of decreased care quality and further heightens the pressure on nurses who must work in an increasingly unsatisfactory environment (Hairr, Salisbury, Johannsson, & Redfern-Vance, 2014; Lee, Dai, Park, & McCreary, 2013). With increased technological demands, increased patient acuity, and the complexities associated with the ongoing nursing shortage, the retention of experienced bedside nursing staff is critically important (Aiken, Clark, Sloane, Sochalski, & Silber, 2002). Nurses are needed to ensure patient safety is not compromised. As such, obtaining a greater understanding of the relationships between hospital ethical climate and the role of conscience using scientific investigation is significant for all healthcare stakeholders. The research findings will provide evidence to add to the body of nursing science and extend the literature in the area of clinical ethics practice.

### **Nurse Leaders**

The nurse leaders' work is a delicate balancing act of respecting an individual's conscience, fairly distributing work assignments and reconciling these to keep the hospital services uninterrupted (Oak, 1996). They must work to ensure that the acute care environment does not become refractory to change, which can undermine the nurse's need for active moral dialogue with other staff members and management during ethical dilemmas. From an organizational systems perspective, reconciling ethical values that guide behaviors for nursing units is an imperative for nurse leaders and other executives. Establishing, maintaining, and promoting conditions of employment that enable nurses to practice with professional autonomy and self-regulation are necessary to support nursing standards and for assuring quality care (ANA, 2015). Principles that undergird nursing

practice with social, religious/spiritual, cultural and other frameworks must also be considered.

Nurse leaders can struggle to ensure that required patient standards of care are met when potential threats to staffing occur as a result of a nurse's refusal to participate in procedures that he/she may deem as morally objectionable. However, health care institutions face the added dilemma of having to ensure sufficient staff to meet patient care needs when a nurse opts out of certain procedures that may violate that nurse's conscience (Pope, 2010). The present study findings may help nurse leaders identify solutions to develop internal ethical support systems for nurses. This can include support mechanisms for the nurse who expresses an objection based on conscience and for other team members who must then assume a difficult ethical patient situation to cover for the nurse who is refusing to participate in the patient's clinical procedure. New strategies to address the issue of moral distress may well emerge once there is a recognition of conscience as the emotional conflict between what should be done as opposed to what is actually done, and that such is a source of ongoing stress when conflicts are not addressed (Morton & Kirkwood, 2009). The study results will provide an opportunity for nurse leaders to design and implement a coordinated and integrated response that should include nurse involvement and dialogue from all levels of the organization.

### **Definition of Terms**

*Conscience:* The mental process that strives to maintain an individual's authenticity and integrity by alerting the individual to potential violations of values and actions, and acts on those violations by persistent badgering or harassing of the person until the violations (both general and specific) are remedied or the person becomes

desensitized to the warnings (Juthberg, Eriksson, Norberg, & Sundin, 2008; McHale, 2009; Morton & Kirkwood, 2009). It makes individuals aware that they ought to act or not act in a given situation and/or that their actions are wrong or not good enough (Glasberg et al., 2006).

*Conscientious objection:* The rejection of some action by a healthcare provider, primarily because the action would violate some deeply held moral or ethical value about right and wrong (Odell, Abhyankar, Malcom, & Rua, 2014). It is based on an individual's maintenance of commitments to core moral principles or beliefs (Wicclair, 2011). Within the nursing profession, it refers to the refusal by a nurse to execute an action or participate in a specific situation on the basis of conscience (Lachman, 2014; Waller-Wise, 2005). The nurse invoking conscientious objection has no objection to the person, but objects to the act the person wishes to have performed (Edwards, 2010).

*Hospital ethical climate:* The organizational condition of the acute care setting where several parties including healthcare leaders, nurses, physicians, patients, family members, and ancillary staff emphasize that caring about the quality of one's work and patients' treatment is valued by the group and forms the basis of a just climate (Gastmans, Dierckx de Casterie, & Shotsman, 1998; Hart, 2005); the perceptions of the organization that influences attitudes and behavior and serves as a reference for employee behavior (Olson, 1998); reflects shared moral values as defined by each discipline's professional code of ethics; the environment that allows for agreement and disagreement on ethical issues (Olson, 1995; Kelly, 1996).

*Louisiana State Board of Nursing (LSBN):* The regulatory agency for registered nurses in the state of Louisiana. They function to “safeguard the life and health of the

citizens of Louisiana by assuring persons practicing as registered nurses and advanced practice nurses are competent and safe” (LSBN, 2016).

*Moral distress:* The painful feelings or disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles: lack of time, lack of supervisory or peer support, exercise of medical power, institutional policy or legal limits (Corley, 2002; Epstein & Hamric, 2009; Jameton, 1984); the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards (Varcoe, Pauly, Webster, & Storch, 2012).

*Perceptions of conscience:* Conscience is perceived in six dimensions: authority, warning signal, demanding sensitivity, asset at work, burden, and depending on culture (Dahlqvist et al., 2007).

*Registered nurse:* An individual who is licensed to practice after the successful completion of an accredited nurse education training program via the hospital diploma option, or an associate of science in nursing degree, or a bachelor of science in nursing degree (AACN, 2004) and passing the National Council Licensure Examination for Registered Nurses (LSBN, 2016).

*Stress of conscience:* A type of stress resulting from a troubled conscience (Glasberg et al., 2006) caused by institutional obstacles as well as self-selected actions or neglect (Glasberg, 2007); described as an important aspect of ethical decision making (Tuveesson, Eklund, & Wann-Hansson, 2012); deemed as a product of the frequency of the stressful situation and of the perceived degree of troubled conscience (Glasberg, 2007).

*Troubled conscience:* A positive force that develops moral values (Alden, 2001) but is not situation dependent (Dahlqvist et al., 2007); creates an individual's awareness of values, even though its negative consequences are more frequently described (Miceli & Castelfranchi, 1998); experienced as feelings of guilt, shame or disharmony if the conscientious person believes that the act was wrong or bad (Beauchamp & Childress, 1989), and threatens the person's self-image (Allport, 1955) and health and well-being (Dahlqvist et al., 2007).

### **Assumptions and Limitations**

This study was based on several assumptions. It was assumed that the nursing ethical climate model and Corley's Moral Distress Theory can be applied to factors associated with ethical climate, perceptions of conscience and stress of conscience. It was expected that nurses choose their profession and bring with them moral values (Pattison, 2001). Nurses are also able to perceive ethical climates in the hospital setting where they are employed. It was assumed professional codes of conduct are used by the nurse to provide guidance for acceptable ethical practice or behavior. Nurses act, think and believe in logical, rational ways in the hospital environment. The researcher assumed that nurses can have difficulty resolving ethical problems in the workplace. It was expected that nurses working at different hospitals may perceive the ethical climate differently. Another assumption is the urge of personal conscience to conduct certain actions varies between registered nurses and can also be varied in different work settings (Dahlqvist et al., 2007).

There are two key topical assumptions of the study. First, ethical climate, perceptions of conscience and factors which may cause a stress of conscience differ



between nursing departments and hospital organizations. This can be due to the variety of patient diagnoses and procedures which are distinct to each nursing unit. Staffing patterns, organizational missions or unit philosophies and the size of the institution may also contribute to nurse perceptions. Second, social factors affecting a nurse's beliefs, moral codes, intentions and interactions can be correlated with the ethical climate of the work environment.

There are three methodological assumptions in this study. It is expected that nurses' experiences with hospital ethical climate and moral distress as well as their perceptions and beliefs about the use of conscience can be quantitatively measured and tested. Second, the researcher will not be able to observe subjects completing the survey and assumes that the intended subject is the person who completes the survey. Third, the proposed study utilizes a postpositivist paradigm to examine the variables of ethical climate and perceptions of conscience on stress of conscience in registered nurses working in hospitals in Louisiana. The intent of the postpositivist lens is to strive for objectivity in the research study and to be as neutral as possible (Polit & Beck, 2012). Research knowledge and postpositivistic views are quantifiable and measurable to gain scientific knowledge through deductive reasoning (Neuman, 2003).

There were also several limitations associated with this study. One limitation was that the researcher did not have direct contact with the participants. The success of nursing research is dependent on the subject's willingness to participate, including responding to surveys (Ulrich & Grady, 2004). The data was collected only in Louisiana. Therefore generalizations to other geographical locations or nurse populations may not be applicable. In consideration of the registered nurse demographics in Louisiana, the nurse

population is predominantly female and the racial distribution is largely Caucasian (non-Hispanic) at 81% (Louisiana State Board of Nursing, 2014). Male nurses and those from other racial backgrounds were underrepresented. Research findings may not be generalizable to other nurse populations with a different demographic makeup. Another limitation was that ethical issues might have differed and been unique to the patient population, practice setting, and the availability of various resources within a particular hospital to address the issues (Ulrich et al., 2010).

The survey instruments utilized for this study involved Likert scales. Participants were asked to self-report their attitudes and beliefs on the topics of ethical climate, perceptions of conscience and stress of conscience. Bordens and Abbott (2013) reported that self-reported data is easy to use and versatile, but it may be difficult to determine if respondents are being honest and are perhaps responding in a socially desirable way. Another potential issue is that some participants may have provided answers that they believed were organizationally correct.

This research utilized a descriptive correlational design. An additional limitation to this study was that causal connections could not be made. With correlational studies, the researcher is not able to manipulate the variables and this prevents identifying the effects of one variable on another (Bordens & Abbott, 2013). Due to this limitation, it was not possible within this study to demonstrate a cause and effect relationship between the hospital ethical climate, perceptions of conscience and stress of conscience.

### **Nature of the Study**

Situated in the discipline of nursing, this was an analytic, ontological investigation of registered nurses who work in the hospital environment in a southern

U.S. state. This study used a quantitative descriptive methodology with two independent variables and one dependent variable. Compared to previous studies, a significant difference in demographics was identified for this research.

Two theoretical models were used to examine the relationship between the hospital ethical climate and perceptions and stress of conscience as perceived by registered nurses in the state of Louisiana. Polit and Beck (2012) found that researchers sometimes combine elements from more than one theory or model as a basis for deeper study and to generate hypotheses. Victor and Cullen's (1988) ethical climate theory and Corley's Moral Distress Theory (2002) provided clarity and new information about how the independent variables, ethical climate and perceptions of conscience, may be related to the dependent variable stress of conscience in registered nurses in the acute care environment.

To the nurse, there is no illusion about external constraints which may conflict with personal values as these are generally beyond the nurse's control (Woods, 2014). The list expands annually, but decreased organizational support across all management and staff levels, indifferent and unsupportive work environments, organizational cultures, poor leadership, lack of sufficient resources, recruiting and retention issues, government regulatory intrusion and ambiguous policies are the most common (Pauly, Varcoe, Storch, & Newton, 2009). The ethical climate involves the contained, but clear values that direct healthcare delivery and create the work environments in which care is delivered (Rodney, Hartrick, Doane, Storch, & Varcoe, 2006). Values reside deeper than ethics in the person and are the result of conscious and unconscious convictions and actions (Jameton, 1994; Spitzer, 2011). From these constructs the independent variables,

ethical climate and perceptions of conscience, were developed. Ethical climate was measured by survey questions which examined the nurses' attitudes on the current ethical work environment in the hospital setting.

The perceptions of conscience variable was also measured by using a survey which examined the nurses' belief about the origins of conscience, its key characteristics and functions and the reliability and importance to the nurse (Dahlqvist et al., 2007). Understanding how ethical climate and perceptions of conscience may relate to a stress of conscience will add critically needed information to the understanding of nursing ethics.

Corley's Moral Distress Theory provides for additional investigation on nursing conscience. The present study adds to Corley's framework by providing a possible antecedent explanation to the concepts of moral intent to act and moral courage. Acting against what conscience dictates may lead to moral distress, moral residue, disengagement, burnout, emotional exhaustion, and fatigue (Corley, 2002; Epstein & Delgado, 2010; Lachman, 2009; Meltzer & Huckabay, 2004; Oh & Gastmans, 2015). The literature, however, is sparse on factors that explain the nurse's moral intent and how a troubled conscience may or may not support the nurse's decision to act with moral courage. Therefore, the dependent variable, stress of conscience, was identified and was measured utilizing survey questions which focused on the amount and frequency a troubled conscience may be experienced by a nurse within the hospital environment.

### **Organization of the Remainder of the Study**

The following chapters will include an in-depth discussion of the multiple regression analysis of the variables as well as the descriptive statistics. Chapter 2 includes a review of the critical literature relevant to ethical climate, perceptions and stress of

conscience in nursing. Chapter 3 specifies the study methodology to include research design, population sample, setting, survey instruments, measures, data collection procedures, data analysis and ethical considerations. Chapter 4 addresses the data analysis and research findings. Chapter 5 summarizes the research findings, discusses the results, suggests topics for further research in nursing bioethics, and discusses the implications for the nursing profession and healthcare leaders.

## **CHAPTER 2. LITERATURE REVIEW**

### **Introduction**

The concepts of ethical climate, perceptions of conscience, and stress of conscience in the nursing field have been examined by several past researchers (Ahlin, Ericson-Lidman, Norberg & Strandberg, 2012; Ericson-Lidman & Ahlin, 2015; Glasberg, Eriksson, Norberg, 2006; Olson, 1998; Wallin, 2013; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015). The intent of this literature review is to present a setting, based on previous research, which will provide the context for the present study. The premise of this study was that registered nurses experience an ethical climate as part of the larger acute care hospital environment and that this experience, along with individual perceptions of conscience, affects a stress of conscience in the nurses. The first section discusses the role of organizational climate, culture, nursing and the hospital ethical climate and related research. The second section provides conceptual meaning of conscience including its premise in nursing and ethical decision making. The third section includes a review of the research literature for perceptions of conscience and stress of conscience. The fourth section addresses the theoretical frameworks as derived from the literature and utilized to guide this study. The fifth section discusses how the present study bridges and addresses the current gap in the research. The final section of this chapter concludes with a summary.

The literature review was carried out in two phases: article selection and analysis. To summarize, the search revealed over 125 articles, 32 of which were primary research studies that separately examined the main criteria listed above in various work settings. The review revealed an opportunity to add to the body of nursing science to address the

gap in the literature that integrates empirical evidence on the role of ethical climate and conscience as perceived and applied by registered nurses.

## **Review of Critical Literature**

### **Organizational Climate**

The concept of organizational social climates observed in work settings was initially proposed by Lewin, Lippett, and White in 1939 (Butcher, 1994; Swiller, 2011). As interest in group dynamics in the workplace grew over the next five decades, early researchers attempted to define climate as having enduring situational or organizational components that members perceive (Forehand & Gilmer, 1964; Schneider & Bartlett, 1968). Schneider (1983) added to the initial framework by suggesting that meaning, as perceived by those in the organization, creates a human climate.

Early scientific investigations into organizational climate began to take shape within the fields of organizational behavior and industrial psychology (Olson, 1995) and in the field of business ethics (Kahn, 1990). Additional studies have provided insights into what constitutes an organizational environment. As an example, climate has been explored comparatively to decision-making (Cook & Slack, 1991) and cultural dynamics in the formation of the organizational climate (Moran & Volkwein, 1992). Both the success and fear climates have been investigated in organizations (Barbalet, 1995; Schneider et al., 1994).

The relationship between various work outcomes and organizational climate has also been widely studied (Carr, Schmidt, Ford, & DeShon, 2003; Parker et al., 2003). These include studies on positive and negative work environments and the relationship to employee productivity and job satisfaction. For example, climates in conflict were found

to be associated with a lack of appreciation of work-related responsibilities and roles, misunderstanding among staff members and conflicting decision making (Liedtka, 1989; Morrell, Brown, Qi, Drabiak, & Helft, 2008). Factors that contribute to the health of an organizational system were studied by Garcia, Castillo, and Santa Barbara (2014). They found individuals who felt welcomed and respected and who possess the capability to develop their talents support a healthy and successful organizational environment (Garcia et al., 2014).

In several industries such as business and healthcare, there is a plethora of articles on the concept of organizational climate, yet disagreement appears to exist on its exact meaning. An in-depth review of the literature reveals most definitions, research findings and applications which attempt to explain organizational climate fall under four categories: psychological perceptions, behavioral, employee experience and leadership influence. Each of these provides unique and important perspectives to the concepts of organizational climate.

**Psychological Perceptions.** In the business and organizational psychology literature, a major emphasis of organizational climate has been centered on its perception at the individual level and not just on group characteristics (Ashforth, 1985; James & Jones, 1974; Jones & James, 1979; Schneider & Hall, 1972). The significance of the employee's internal expectations and belief systems are an important influence in the work environment. Perceptions may be internally connected to one's values and beliefs which contribute to the nature of the organization as a whole (Malloy et al., 2009). The work setting's climate has also been described as being the essence of the organization (Meudell & Gedde, 1994). An individual's view of the work environment as a frame of



reference has been considered more important than how others may choose to describe it (James & Jones, 1974; Schneider, 1990). A previous study found that esteem, autonomy and self-fulfillment needs associated with satisfaction are strongly related to organizational climate (Lawler, Hall, & Oldham, 1974).

Organizational climate has also been described as going beyond the individual view. It includes shared staff perceptions of their work setting (Hwang & Hwang, 2011; Lewin, Lippett, & White, 1939). Climate can permeate the inhabitants of the entire work community (Schneider, 1983). It provides meaning to one's overall work experience. Team members' beliefs about their work setting lead them to develop attitudes and analyze various events which govern how they work (Bowen & Ostroff, 2004). The group's perceptions of the organizational climate may be interpreted as 'the way things are for now' and may vary from one subgroup's perspective to another (Malloy et al., 2009). Ultimately, an organizational climate can act to facilitate or stifle individual and organizational goal achievements (Grigsby, 1991).

A secondary study conducted by Stone et al. (2005) revealed organizational climates in different health care settings and identified two common spheres of staff climate perceptions. The first focuses on the central climate which includes the beliefs regarding the leaders' strategies and values, the structural characteristics of the organization such as communication, governance, and the use of information technology. The second domain is the process climate which encompasses working conditions perceptions, including certain supervision elements, group process, work design, and commitment to quality. Working conditions and supervision were found to be significant to employee perceptions of the organizational climate (Stone et al., 2005).

Group perceptions of organizational climate can also be seen as a benefit or a consequence. Employees may perceive climate as the atmosphere that is created by their practices, procedures and rewards (Brown & Brooks, 2002; Schneider, White, & Paul, 1998). These are gradually developed and experienced daily (Schneider et al., 1994). It involves shared perceptions through socialization to the work group (Schneider & Reichers, 1983). The established norms of an organizational climate can also be the manner that determines how employees are dealt with by other members of the group (Miller & Fredericks, 1990).

**Behavioral.** Organizational climate has been defined using behavioral descriptions for both the individual and employee group. The definitions of climate are viewed as an environment of influence which is connected to events, rules and routines within the work setting (Ekvall, 1983). These factors then serve as a guide for the expected behaviors of the members which contribute to the overall environmental setting. Climate involves behaviors that characterize life in an organization – more specifically, it suggests what it is like to be employed in the organization and the overall atmosphere (Ekval & Ryhammer, 1999; Malloy et al., 2009). In the work setting, codes of conduct are often generated from underlying expectations of the climate as established by its members. It influences staff member behavior based on their feelings and how they may think about their organization (Walston, Al-Omar, & Al-Mutari, 2008) and toward one another through social interactions (Isaksen & Ekvall, 2007).

**Employee Experience.** Another concept of organizational climate involves the employee's experience within the work setting. The atmosphere of the work setting can affect the employee both positively and negatively and contributes to the acquisition of

knowledge and builds decision-making skills. The organizational climate is defined as something that is understood according the employee experiences over time (Walston, Al-Omar, & Al-Mutari, 2008). The experiences are often described in terms of meaning based on attributes or characteristics at the employee or unit team level, or from the vantage of the entire organization (Schneider, 1983).

Organizational climate is also an expression of the extent to which members see organizations' features matching their own expectations (Bowditch & Buono, 1989). The employee may modify expectations based on the work environment and personal experience. The interpretations of the work experience resulting from climate may contribute to job satisfaction or serve as contributory factor in the decision to leave the organization.

**Leadership Influence.** Organizational climate has been defined as the relationship between administrators or managers and the subordinates exemplified through esprit, familiarity, and humanistic drive (Hern-Underwood & Workman, 1993). It is comprised of arrangements and group processes that facilitate the attainment of desired behaviors (Slater & Narver, 1995). Obtainment of these behaviors as related to the working and practice conditions are frequently directed and influenced by the leadership team (Clarke, 2006). Managers contribute to the organizational climate by ensuring staff members are productive and that any ambiguity regarding questionable behaviors that may occur is kept to a minimum.

Management teams should understand what their employees believe about the organizational climate (Walston, Al-Omar, & Al-Mutari, 2008). Previous research has shown top managers are often unaware of employees' true perceptions within their

organization and are frequently much more positive than their staff (Walston & Chou, 2006). Even with quality improvement efforts, the climate can determine contextual receptiveness to ongoing development and transition, and the success of managerial interventions (Brown & Brooks, 2002). Employee outcomes involving satisfactions and perceptions of the environment can be influenced by leadership decisions (Clarke, 2006).

### **Organizational Culture**

The concepts of organizational climate and organizational culture are often integrated and researchers have attempted to distinguish the terms. As an example, Brown and Brooks (2002) describe climate as a key indicator of organizational context and note that culture is a basic quality descriptor of the organization. The nature of climate changes in response to stimuli (Schneider, 1983) and cultures within a climate are one source of such stimulation (Olson, 1995).

However, the distinction between climate and culture remains a matter of debate in the organizational studies literature (Ashkanasy, Wilderom, & Peterson, 2000). The idea that culture can be studied systematically stems from an anthropologic approach and this has led to many definitions of organizational culture (Martin, 2002) in the literature. In the business sector, organizational culture centers on what is valued and prioritized in the work community (Hofstede & Peterson, 2000).

Organizational culture can have an effective or ineffective influence on an employer's performance (Casida, 2008; Denison, Haaland, & Goelzer, 2003). It may operate within the environment at an unconscious level and involves the values and beliefs, along with core assumptions which have been learned and shared by employees over time (Brown & Brooks, 2002; Casida, 2008; Morgan & Ogbonna, 2008; Suominen,

Kovasin, & Ketola, 1997). It is not unusual for this to occur as a result of the staff member's attempts to fit in response to expectations of group survival. Such manifestations occur as a means of internal integration into the culture (Casida, 2008). One may also assume that when a group of people such as staff members share significant experiences together to solve external challenges in the workplace, they will develop a common view of the organization itself (Brown & Brooks, 2002; Schein, 2004).

Organizational culture is usually discussed with a set of deeply engrained experiences and ideas that serve as reference for actions in workplaces (Clarke, 2006). Organizational culture includes the formality and informality of norms, rules and customs and is focused on how things work in an organization (Brown & Brooks, 2002). It can reflect the accumulation of leadership decisions over time (Clarke, 2006). Subcultures may exist within any level of the organizational culture and can be strong or weak. Strong cultures have a larger impact on climate perceptions (Ashforth, 1995). Moreover, Degeling et al. (2001) uncovered through empirical research that the dedication to one's profession is often much stronger than to the organization and this imbalance can create potential managerial challenges when change and/or quality improvement transitions are introduced and implemented (Morgan & Ogbonna, 2008).

Cultural beliefs have been found to exist in all levels of a healthcare organization through group norms and practices (Rodney, Pauly, & Burgess, 2004). These viewpoints will also determine how ethical dilemmas are approached and subsequently addressed within the organization (Burgess, Rodney, Coward, Ratanakul, & Suwonnakote, 1999; Johnson, Bottorff, Hilton, Browne, & Grewell, 2002). The implications of such decisions

affect patient care and patient safety issues, technology, cost-containment measures and staff development and training (Clarke, 2006).

### **Ethical Climate**

The ethical climate of an employer-based system is a subset of the larger organizational environment. Different descriptors for ethical climate have been utilized, such as ethical organizational climate, ethical culture, moral climate, ethical environment, the ethical dimension of the organizational culture and ethical work environment (Olson, 1995). However, a new definition applied to the healthcare environment was suggested by Olson (1998). She defined ethical climate as “an organizational construct that can be changed, improved and managed for the betterment of the work environment” (Olson, 1998, p. 346). It includes organizational conditions and practices which allow for discussion to resolve challenging patient care dilemmas and offers a context for ethical decisions in a clinical environment (Olson, 1998).

Over the past two decades, research has revealed ethical climate to be a measurable variable and a central component in the advancement and socialization of ethical and unethical conduct (Victor & Cullen, 1988). More specifically, it delineates to the general perception of what is ethically permissible (as consensus) within the organizational context (Malloy et al., 2009) and it is interpreted in terms of shared meaning (Welk, 1993). Although invisible, the ethical climate in all work settings yields a persistent and powerful sway on the ethical behavior of staff members at all levels of the organization (Humphries & Woods, 2016). Ethical climate can lay the foundation for patterns of expected behaviors as new employees are integrated into the organizational system. Sims and Keon (1997) describe an ethical work climate as an enduring reflection

of egoism, benevolence and principles that frame the right and wrong choices within the context of an organization. As such, it represents the informal, yet collective, perception of individual ontology and what are deemed as acceptable and unacceptable actions which influence ethical climate (Hadjistavropoulos, Malloy, Sharpe, & Fuchs-Lacelle, 2003; Malloy & Agarwal, 2003; Malloy & Hadjistavropoulos, 2004).

A stable organizational system which promotes a positive ethical environment involves key characteristics that include respecting the dignity of others, fostering autonomy, valuing freedom of expression and providing a nurturing environment for personal and professional growth. An ethical climate can emerge out of the interactions that inhabitants of an organization have with each other (Schneider & Reichers, 1983; Victor & Cullen, 1988; Olson, 1998). Through internal and external perceptions, along with interactions which promote morally correct behavior, the integrity of the organization is manifested. According to Silverman (2000), achieving organizational integrity consists of two major elements. The first involves the underlying core values of the culture that creates traction for how the decisions will be made. The second centers on the organization's infrastructure or systems. These include processes and procedures which serve as a conduit for core values reinforcement and ensure actions, decisions and consequences are reflected and aligned in the organization (Silverman, 2000).

In a seminal study of the perception of ethical climate, Victor and Cullen (1988) found that when staff members held similar job positions, they often shared a common perception of the ethical climate even if these employees did not interact with one another. However, empirical research has shown that a variety of ethical climates may exist across multiple departments and are varied based on tenure and job roles, which

suggests that the predominant type of ethical climate may be found in a single work group but not be shared throughout the rest of the organization (Victor & Cullen, 1988; Wimbush, Shepard, & Markham, 1997). Within each workgroup, the ability of the employee to act independently or to be constrained can be the direct result of the existing ethical climate. It is possible therefore to have climates that permit the existence of organizational subcultures to the degree that various subgroups within the institution possess different types of climates (Victor & Cullen, 1988).

### **Hospital Ethical Climate and Nursing**

Organizations have numerous priorities and contain many climates (Brown & Brooks, 2002; Schneider, 1990) and a variety of cultures. The acute care hospital is a unique environment and involves multiple healthcare disciplines to deliver high quality patient care. The hospital organization is fast-paced with multiple layers of complexity that often requires a rapid systems response to ongoing change. Its organizational culture is heterogeneous with multiple goals that are at times conflicting (Karassavidou , Glaveli, & Zafiropoulos, 2011).

Organizational subcultures can also be found within distinct professional and occupational groups with divisions and teams working together (Davies et al., 2000). Each professional group brings with it specific paradigms and approaches to patient care that entail a specialized body of knowledge. One of these groups is the nursing staff. In a majority of medical facilities, the nursing departments have the largest employee representation and nursing staff comprise 40–60 % of total human resources (Chen et al., 2015). Nurses who provide direct patient care play a vital role in planning and executing organizational goals of the hospital (Aryee, Budhwar, & Chen, 2002) and provide the



closest contact and spend the most time with patients (Chen et al., 2015). Therefore, the overall hospital image is affected by nursing quality and indirectly impacts hospital operations (Chen et al., 2015).

The unique beliefs, norms and practices in nursing distinguish it from other professions regardless of the work setting. Previous nursing studies have examined the influence of organizational and ethical climate to different outcomes in nursing and have included, for example, burnout (Chiriboga & Bailey, 1986; Meltzer & Huckabay, 2004) and nurse perceptions of the work environment (Filipova, 2009; Goldman & Tabak, 2010). Nursing practice occurs within a social framework which allows for the simultaneous interaction of interpersonal relations along with organizational and environmental elements (Numminen, Leino-Kilpi, Isoaho, & Meretoja, 2015). In hospital settings, elements of organizational climate and culture are established. It is influenced by beliefs attained during nursing education and experience gained from other work settings (Suominen et al., 1997). A study conducted by Hwang and Park (2014) found nurses' views of ethical climate varied according to different personal and organizational variables such as hospital size and age and experience of nurses. As an example, nurses working in large teaching hospitals and who were over the age of 40 years and had more experience perceived their work environment more positively than those nurses who worked in other settings with less years of experience. The findings provide evidence that organizational characteristics are antecedents of ethical climate (Martin & Cullen, 2006).

The nurse is the primary source for human caring and is central to the rendering of aid, comfort and support to patients and families during times of physical, mental and emotional suffering. Nursing has been called the “morally central profession” (Jameton,

1984, p. 1), and the nurse's desire to care for the suffering is generated by moral reasoning. Fowler (2015) states that an ethic of care starts with the concept of relationship and includes the nurse and the healthcare team. Beyond that, it includes the institution in which care takes place, for the institution's policies and ethos will affect care and the ways in which it is given (Fowler, 2015). The ethical climate is contributory to the dynamic complexity of the hospital environment.

Hospital ethical climate has been explained as the organizational condition of the acute care setting where several parties, including healthcare leaders, nurses, physicians, patients, family members, and ancillary staff, emphasize that caring about the quality of one's work and patients' treatment is valued by the group and forms the basis of a just climate (Gastmans, Dierckx de Casterie, & Shotsman, 1998; Hart, 2005). A hospital environment reflects shared moral values as defined by each discipline's professional code of ethics and it allows for agreement and disagreement on ethical issues (Olson, 1995; Kelly, 1996). Registered nurses abide by an established professional code of ethics which serves as a general guide for the profession's members and as a social contract with the public whom it serves (Fowler, 2015). The nine provisions within the Code of Ethics for Nurses provide the ethical framework for professional conduct within the workplace. It has a significant influence on expected nurse behaviors and the nurse's commitment to the patient as a care provider and advocate. Ethics in nursing is one of moral suasion, which has been described as persuasion exerted or acting through and upon the moral nature or sense (Fowler, 2015). In an ethical climate such as the hospital setting, it involves peer or community pressure placed upon one to conform to moral expectations and may include reprimand, rebuke, censure, shaming, shunning, exclusion

from community or association (Fowler, 2015). These characteristics, in addition to individual moral agency, background and previous experience of the nurse, create the layers of subcultures found within nursing departments and the hospital ethical climate. This identification by nurses has been linked to loyalty and commitment to the nursing unit rather than the overall hospital organization (Mowday, 1999).

Early research involving the hospital ethical climate and nursing began in 1990 and has steadily increased nationally and internationally. The important role of the nurse-physician relationship has been studied. Research conducted by Hamric and Blackhall (2009) examined registered nurse and physician attitudes on caring for dying patients in intensive care units with focus on moral distress, ethical climate and satisfaction with quality of care. The nurses reported a lower level of collaboration, higher moral distress and a more negative ethical environment than did attending physicians. Nurses have been found to be most troubled when they feel pressured to provide aggressive treatment that they believe is not warranted (Hamric & Blackhall, 2007; Heland, 2006). Nurses also perceived distressing situations occurring more frequently and a lower quality of patient care than did physicians. They appear to be especially sensitive to these feelings when they must implement a plan of care for a patient for whom they have had little involvement with the surrounding decisions (Malloy et al., 2009). Although nurses are independent and autonomous in their practice, they are not always consulted about decisions made by the physician or other disciplines involving the medical plan of care (Malloy et al., 2009). Another significant finding in the Hamric and Blackhall (2009) study was the positive relationship between lower nurse-physician collaboration as reported by nurses and a perceived negative ethical climate. This association between

employee distress and ethical climate has also been addressed by Ulrich and Soeken (2005), who found that 45% of the total variance in ethical conflict was explained by the variables of ethical environment and ethical concern.

Similar research by Han (2014) studied hospital ethical climate and turnover intentions among nurses. The findings revealed that nurses who perceived a negative ethical climate were highly likely to resign from their positions. Nurses who indicated that they perceived higher positive ethical climate were more apt to stay in their current work settings. Relationships associated with low nurse-physician collaboration correlated with a negative ethical climate and the nurses' intent to leave. Seago (1996) found that hospital nurses have identified several environmental issues associated with increased work stress including poor and inconsistent staffing, heavy workloads, physician conflicts, addressing the needs of dying patients, and the overall physical challenges of shift work. Previous studies support the perceived importance of the nurses' ability to collaborate as a partner with physicians regarding patient care decisions and findings revealed that negative relationships lead to increased job dissatisfaction, negative ethical climate and intent to leave (Chambers, 1990; Gaudine & Thorne, 2012; Hart, 2005; Hwang & Park, 2014; Malloy et al., 2009; Stichler, 1990; Suhonen et al., 2015).

Research on hospital ethical climate, nursing peer relationships and collegiality in the workplace has also been conducted. In a study by Silen et al. (2012), having the support of colleagues and being able to work cohesively as a team was perceived by nurses as contributing to positive ethical climate. Findings revealed that nurses correlated collegiality with their ability to provide quality care to patients and meeting needs of each other. The nurses expressed that the prerequisites for positive patient care delivery must

include nursing responsibilities being shared among team members according to established standards for performance and meeting the nurses' needs (Silen et al., 2012). The issue of teamwork and its role on ethical climate has been found to have a positive relationship in additional studies (Corley et al., 2005; Hamric & Blackhall, 2007; Hamric et al., 2012; Pauley et al., 2009). Recent research has supported the problems associated with poor teamwork among nurses, physicians and other hospital staff. Whitehead, Herbertson, Hamric, Epstein and Fisher (2015) found that poor team communication and inconsistent or lacking provider continuity related to aspects contributing to an ethical climate, namely continuity of care and interprofessional communication.

Communication barriers can affect the ethical climate for nurses. This can be related to a perception of uneven power bases which may exist in an organization such as the healthcare environment. In a multinational qualitative study, Malloy et al. (2009) found that nurses perceived a lack of equivalence between themselves, physicians, and often patients and their families. They noted that a lack of empowerment involving the hierarchical nature of nursing and medicine characterized this difference. Their findings were consistent with two large-scale surveys carried out in the United States by Sirota (2008) in which nurse–physician relationships remained similar over a 17-year period. In that study, staff nurses working in hospitals reported dissatisfaction with their relationships with physicians and some nurses believed that this was because physicians were seen as most powerful within the hierarchy (Sirota, 2008). Nurses in the Malloy et al. (2009) study reported that they often attempted to discuss patient concerns with physicians but were disregarded. A significant finding was that some nurses indicated that they decided to remain silent as matter of respect or due to frustration. Professionals

who experience ethical dilemmas in clinical practice report feeling distressed and sometimes powerless due to the level of obvious unmanaged and irresolvable ethical situations in the workplace (Wagner & Hendel, 1998; Wall & Austin, 2008).

Other studies have examined ethical climate, professionalism and perceptions of team competency among physicians and nurses. Research by Pauly et al. (2009) found that increased levels of the intensity and frequency of moral distress are associated with concerns over nurse staffing and physician competency. However, the research findings also established that nurses associated feeling of intense moral distress regarding their own competence and their personal perceptions of other registered nurse competencies. As such, moral distress and ethical climate were found to be highly correlated. Similar research by Numminen, Leino-Kilpi, Isoaho, and Meretoja (2014) investigated recent nurse graduates' professional competence perceptions and ethical climate. The findings indicated a higher degree of professional competence, increased job satisfaction, and decreased turnover intentions were associated with a positive perception of the climate. Nurses who had lower confidence levels in their professional competence perceived the ethical climate more negatively. The literature review by Georges and Grypdonck (2002) found that nurses reporting feelings of powerlessness had limited ethical decision making skills.

The issue of professional competency contributes to the patient safety environment and also affects the hospital ethical climate. Nurses play an integral role to creating and sustaining safety and ethical climates which are considered types of organizational climates (Victor & Cullen, 1987; Zohar, 1980). Major factors influencing patient safety include both culture and climate (Walston, Al-Omar, & Al-Mutari, 2008).

A workplace safety culture can be equated to the understanding of its workers, and the key practices set in place by the organization to recognize hazards are central to the norms and roles which govern it (Pidgeon, 1991).

Ensuring that this effort remains seamless requires consistent team interaction, trust and open communication between all members of the healthcare staff. These relationship characteristics can contribute to the established culture and climate of a particular nursing unit, but can prove detrimental if a break down among the team members occurs. In a study by Clarke, Sloane and Aiken (2002), hospital nurses' exposure to blood-borne pathogens was found to be related to staffing levels and the organizational characteristics of their hospital units. Further, the study showed that a nurse's risk of injury from used sharps was associated with aggregate-level characteristics of the hospital nursing units, such that poor working climates increased the risk of actual injury and near misses (Clarke et al., 2002).

Another potential outcome of poor climate is medical errors (Ludwick & Silva, 2003). In an investigation by the Joint Commission on Accreditation of Healthcare Organizations (2004) of labor and delivery (L&D) units found that poor communication among physicians and nurses was a primary cause in over 80% of perinatal injuries and deaths. This is significant due to the often unexpected, emergent need that arises during the patient's intrapartum experience which requires rapid intervention by the hospital team. The ability to intervene successfully is contingent upon the ongoing exchange of information related to the patient's health status. A previous study found that 40% of maternal deaths and 45% of near miss morbidities was related to poor teamwork (Geller, Rosenberg, & Cox, 2004).

Research by Hwang and Park (2014) investigated nurses' perception of ethical climate, medical error and intent to leave. Nearly 20% of the 1,826 nurses in the study indicated that they had made at least one error during the previous year. The findings established that nurses' medical error experiences and their intent to leave were significantly related to the ethical climate. The nature of the care unit where the nurses worked did not matter to any significant degree in their perceptions of the ethical climate. Nurses reported fewer medical errors when a more positive perception of the patient dimension existed. Hwang and Park (2014) also found that a positive ethical climate contributed to decreased frequency of situations which caused moral distress and reduced low quality, unsafe patient care events. The findings supported a relationship between positive ethical climate and nurse retention. Previous studies have revealed similar findings on moral distress and the nursing work environment (Atabay, Cangarli, & Penbek, 2015; Gutierrez, 2005; Hamric & Blackhall, 2007; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010; Wadensten, Wenneberg, Silen, Tang, & Ahlstrom, 2009; Wilkinson, 1987).

In a study by Maxfield, Grenny, McMillan, Patersons, and Switzler (2005), the researchers identified seven conversation areas which are particularly difficult, but are still necessary for healthcare team members. These areas of discussion are broken rules (including dangerous patient care shortcuts), mistakes, poor teamwork, lack of support, disrespect, micromanagement and incompetence. Nurses play an integral role in assuring open professional communication channels exist in the workplace. Their knowledge about patient needs, training and expertise must be utilized to identify potential problems. If nurses are unable to be recognized for their expertise and be regarded for their



expressed patient concerns, then the safety of patients can be compromised. Further, evidence exists that when nurses perceive they have failed as advocates for their patients or that physicians do not respect the wishes of their patients or families, they experience frustrating moral distress. (Schluter, Winch, Holzhauser, & Henderson, 2008).

The study by Maxfield et al. (2005) revealed that many healthcare employees, including nurses, regularly observe their colleagues taking shortcuts perceived as dangerous, failing to extend support, making mistakes, or appearing to be critically incompetent. However, the research also reveals that fewer than 10% share their concerns by speaking up. Fowler (2015) stated competence in the nursing profession is the very rock-bottom acceptable practice level, under which no practitioner should fall. With professional growth, the nurse moves beyond basic education and simple competence towards a higher standard of practice and a progression towards the standard of excellence (Fowler, 2015).

Research has also revealed a positive relationship among nurse leaders and their role in promoting job satisfaction and positive ethical climates (Donahue, 1986; Huang, You, & Tsai, 2012). In another study by Joseph and Deshpande (1997), a caring climate promoted by nurse supervisors influenced overall job satisfaction and this supported the ethical climate of the nursing unit. Nurses who reported being dissatisfied with supervisors were highly likely to leave their positions. An efficiency climate which focused on cost controls had a highly negative relationship between nurses and nurse supervisors due to perceptions of impacts to quality of patient care. A similar study by Hart (2005) found that professional and positional turnover is affected by higher patient loads and the evidence suggested ethical climate was contributory to nurses' deciding to

depart from their positions or exit from the nursing profession. These findings are consistent with Holly's (1989) earlier research which revealed critical care nurses perceive minimal environment and social support from nursing and hospital administrators and physicians during difficult ethical situations. Nurses identify more closely with their own local nursing units or wards than with the hospital organization and this connection is stronger in its relation to important behavioral outcomes such as turnover (Pretholdt, Lane, & Mathews, 1987). Therefore the role of the nurse leader in influencing the nursing unit is important in supporting a positive ethical climate. Han (2014) noted that findings from her study indicate that promoting the hospital ethical climate for physicians and managers assists in improving nurse retention.

As part of the organizational climate, fostering a positive safety environment is critical to the success of a healthcare system. Healthcare providers are better able to meet patient care quality expectations if there exists a climate of blamelessness, support, participation, innovation, creativity, inspiration, continuing education, communication, optimism and problem-sharing (Luthans et al., 2008; Moran, 2003). Nurses play an integral role to ensure patient safety is a priority. A description of a preferred organizational climate is one that promotes nurse autonomy and offers more support and nursing control in decision-making at the bedside with improved physician relationships (Aiken et al., 2002). Having control over professional practice was shown to have a positive, significant relationship to nurses' turnover intentions in Hart's (2005) study. Those results indicated that when nurses play a large role in decision-making within their own practice and through collaboration with doctors, retention rates for institutions are higher (Hart, 2005).

## History of Conscience

Conscience has been historically associated with religious, secular and philosophical meanings. Connections between conscience and the major religions such as Judaism, Christianity, Hinduism, Islam and Buddhism are referenced as tenants of their faiths. It has been accepted in theocratic circles and in theology throughout known history, such as descriptions found in the Old Testament of the Bible, of an individual believer able to resist imposed practices contrary to his beliefs, even though the obligation often carried negative personal consequences (Orr, 2010). In the Islamic tradition, the Quran refers to God as the creator of the soul and conscience (Noss, 1968). The general religious view of conscience is seen as a communication from God or a Higher Power. It is referred to as an inner voice that speaks to the individual self about God's will regarding good versus evil actions and makes one aware of what should be done through the experience of feeling peace or guilt (Hoose, 1990; Noss, 1968; Ricoeur, 1992; Smart, 1989). It may be simply understood as metaphysical guide that acts in a judicial way to direct a person's actions (Genuis & Lipp, 2013).

Traditionally, conscience seems to address two key contexts. The first is from the Latin word *conscientia*, which refers to a joint knowledge and implies a social consensus as to inner knowledge of what is right and wrong. The second context is associated with *synderesis*, which involves applying one's moral principles to actual situations as part of an internal conviction (Fagothey, 2000; Gladwin, 1977; Wood, 2006). The use of one's conscience also enables a person to use discernment (Lawrence & Curlin, 2007) in choosing what is deemed internally as the correct action. However, Wicclair (2011) argued that while conscience may be used to seek meaning in an individual's own way,

this search for ultimate meaning can involve, but does not necessarily require, religious beliefs for guidance. Moral conclusions can vary and be reached by religious people and secular persons due to their differences in the ordering and application of values (Cook, 2007).

Conscience as a human right began to gain recognition in secular circles during the Enlightenment and was expressed by Thomas Paine and Thomas Jefferson (Orr, 2010). In United States history, McConnell (1996) has noted that 18<sup>th</sup> century writers were concerned about a particular instance of the right of conscience, namely, the right of religious freedom. According to White (1987), James Madison argued that the religion must be left to the conviction and conscience of every man and that it was the individual's right to exercise it as was dictated. Madison believed that the use of one's conscience was an inalienable right for two reasons. First, individual opinion as contemplated in one's own mind could not follow the dictates of others. Second, he believed that conscience was a right of men and as such, it was also a duty towards the Creator. According to Madison, the duty that people owe to God is the basis for the inalienability of the right of conscience (McConnell, 1996; White, 1987). This was referenced in earlier versions of Madison's first amendment to the Constitution, though this was obscured in the final version (Orr, 2010).

During the 19<sup>th</sup> century, support eventually began to grow for a general understanding of conscience and appeals to conscience that extended beyond faith-based and metaphysical interpretations (Barfield, 2007; Card, 2007; Curlin, 2007; Hardt, 2007; Lawrence & Curlin, 2007; Savelescu, 2007; Wicclair, 2007). From a sociological and psychological perspective, conscience has been identified as an internal set of

conventions and social norms similar to the Freudian superego that succumbs to a repressive morality and is not infallible (Benjamin, 1995; Sulmasy, 2008). It was considered by Kohlberg (1987) to be part of the psychological moral maturity of the person. Erikson deemed conscience to be normally developed during the preschooler phase of personality development (Wurgaft, 1976). Rose (1999) added to this explanation by arguing that the growth of one's conscience involves the ability to gradually increase control over impulsive behavior, incorporating moral standards instilled by parents, developing feelings of shame and guilt, experiencing the consequence and practice of rules and learning a sense of justice. Conscience also came to be considered as an ethical lens through which moral actions relating to one's self and character could be understood (Blustein, 1993).

### **Conscience and Health Care Ethics**

The literature on conscience in healthcare ethics is extensive with a significant amount of anecdotal discussion and debate. However, a clear definition of conscience in the medical and nursing literature is lacking, and previous authors do not offer explicit meanings of the terms. Genuis and Lipp (2013) summarized various descriptions by explaining that conscience consists of two main components in bioethics. First, a person's conscience is rooted in a fundamental responsibility to consider all situations within a framework of ethical obligation. Second, this responsibility leads to judgments and reasoning about the types of actions and behaviors which characterize a moral life. Conscience, then, represents the decision-making capacity of the human mind, founded on a desire to live an upstanding and desirable life which promotes good for oneself and for others (Genuis & Lipp, 2013; Sulmasy, 2008).

A person's life experience has also been given consideration in relation to conscience. Kukla (2002) stated that conscience flourishes from one's lived experience. Birchley (2012) proposed that human conscience seems to involve a moral decision-making faculty, influenced by a rational perception of the observable world which is both reflective and reflexive. The reflective nature of conscience scrutinizes past, present and future decisions, while the reflexive component provides instant feedback in the form of internal dissonance or discomfort when an individual is compelled to choose a potentially problematic or immoral decision or action (Birchley, 2012). Conscience's role is as the informer of value conflicts and as such, it appears to cause the infliction of distress on people once it is realized (Morton & Kirkwood, 2009). The implication is that moral decisions based on one's conscience may occur as a result of personal learning over time. The experiences associated with peaceful conviction or psychological pain from guilt may then serve as a guide for future encounters with moral dilemmas. In healthcare, nurses may reflect upon similar circumstances in their daily work and utilize previous lessons associated with past patient care experiences to navigate moral dilemmas. Studies examining ethically difficult situations have revealed that healthcare providers stated that their consciences served as a guide in deciding to carry out particular actions and further caused them to review and examine their motives and actions for the protection of the patient and their integrity (Jansson, Norberg, Sandman, & Astrom, 1995; Nelms, 1996; Soderberg, Gilje, & Norberg, 1997). Similar research findings have shown that prior experiences with a troubled conscience assist physicians and nurses in making decisions in future situations and as a learning experience on how to integrate the use of their consciences to make additional difficult and potentially controversial decisions (Rose,

1999; Torjuul, Nordam, & Sorlie, 2005). These care providers seemingly acknowledge that their moral compass is guided by their consciences (Dahlqvist et al., 2007).

In a contrasting perspective, Cook (2007) posited that conscience is individualistic, as it can be both overly and under sensitive, implying that a person can develop a thorough awareness of an inner voice or choose to ignore the voice and force of conscience. This may be the result of several factors related to personal interpretations of negative past experiences. Nurses, as an example, can be at risk of being closed to their internal moral directives due to unresolved ethical patient dilemmas and staff conflicts as a means of coping.

Preliminary evidence garnered from the healthcare literature is notable. In addition to conflictual feelings associated with guilt, anger, resentment, sorrow, frustration, and powerlessness when faced with moral distress (Corley, 2002; Kain, 2007), researchers have begun to describe anecdotal long-term sequelae of the associated moral trauma inherent with ethical distress, sometimes resulting in conscience violation. Health professionals, including nurses, may display emotional difficulties and experience job burnout and/or dissatisfaction, feelings of inadequacy, and challenges in personal and professional relationships, all affecting patient care in a negative way (Cavaliere, Daly, Dowling, & Montgomery, 2010; Corley, 2002; Mitton, Peacock, Storch, Smith, & Cornelissen, 2010; Rushton, Kaszniak, & Halifax, 2013; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Unless the root causes of the distress are dealt with and resolved, individuals will eventually become programmed to ignore the warnings and become desensitized to the alert (Cook, Lawrence, & Curlin, 2007). This can actually weaken one's ability to recognize future ethical dilemmas (Lawrence & Curlin, 2007).

## **Perceptions of Conscience**

Few empirical studies have explored the meaning of conscience to nurses and its relationship to ethical decision making in the workplace. The conceptualization of how conscience is viewed by nurses was originally studied by Dahlqvist et al. (2007) who, as a result of their seminal findings, developed the Perceptions of Conscience Questionnaire after extensively reviewing the literature to gather and synthesize concepts representing different theoretical understandings of conscience. The focus of their research was to utilize this instrument to study possible relationships regarding healthcare providers' attitudes and beliefs on where conscience emanates, what the functions and qualities are, its reliability and the interpretation and demands of conscience (Dahlqvist et al., 2007). Their assumption was differing perceptions of conscience would likely involve unique demands on individuals due in part to the lack of a universally agreed upon definition. The authors coined the term "troubled conscience" and explained that in a general approach, it meant to have a conscience that hurts. For nurses, this discomfort could be stimulated by experiencing conflicts between internal and external circumstances and demands. It could also occur due to a knowledge deficit or lack of resources to provide adequate care or by demands on the nurses to act inconsistently with their consciences (Dahlqvist et al., 2007). The general observation in their study was healthcare providers often invoke conscience as part of their work lives when facing ethically difficult situations, and therefore, their consciences may directly or indirectly influence them.

The initial study on perceptions of conscience by Dahlqvist et al. (2007) involved multiple types of healthcare providers from three different work settings (municipal health, hospital setting and at a healthcare conference). The response rates for the



municipal health setting involved 50 nurses, nine physicians, and 96 nurse assistants. The hospital setting yielded 118 nurses, 17 physicians, and 15 nurse assistants as study participants. The researchers utilized a principal component analysis, which indicated conscience can be perceived as a warning sign, authoritative, and an asset, or conversely, as a burden, and is dependent on the cultural context, while at the same time perceptions of conscience varied widely among healthcare team members (Dahlqvist et al., 2007). Responses to survey questions yielded support for each category. Survey statements such as “We should follow our conscience no matter what other people think”, “Our conscience weakens if we do not listen to it”, “God speaks to us through our conscience” and “When I follow my conscience, I develop as human being” correlated with the perceptions of authority. For conscience as a perceived warning signal, items such as “We cannot avoid the voice of conscience” and “Our conscience warns us against hurting others/ourselves” demonstrated a positive relationship. The concept of being responsive to one’s conscience was also explored. For the demanding sensitivity factor, survey statements such as “The voice of conscience must be interpreted”, “You need inner peace to hear the voice of conscience” and “Our conscience weakens if we do not listen to it” each demonstrated a positive relationship to this category.

The concept of following what one’s conscience dictates was examined by asking questions associated with conscience being perceived as an asset versus a burden. Statements such as “At my workplace, I can express what my conscience tells me” and “I follow my conscience in my work” were used to measure conscience as an asset. The ability of healthcare personnel to be able to follow their consciences at work or being

able to express it when deemed necessary supports the positive aspects of conscience as an asset (Dahlqvist et al., 2007; Kelly, 1998; Torjuul et al., 2005).

Conversely, conscience as a burden was investigated using survey items such as “I have to deaden my conscience to keep working in healthcare” and “My conscience is far too strict”. Dahlqvist et al. (2007) found those who rate their consciences as very strict can score differently on certain items than others who assess their consciences as less strict. They noted a troubled conscience may not be dependent on a particular situation but may result from its relationship to the individual’s personal beliefs and values. The researchers built upon the earlier findings by Sorlie, Jansson, and Norberg (2003) showing that one’s conscience can become a burden when it is perceived as being too strict, especially if healthcare personnel cannot express or follow the demands of conscience.

An additional item in Dahlqvist et al. (2007) examines the relationship between cultural relationship and conscience. The statements associated with this factor are “Our conscience can give us the wrong signals” and “Our conscience expresses our social values”. The prompting of conscience to conduct certain actions appears to differ among healthcare personnel across various cultures and background according to the study results. How conscience is perceived can vary and cultural influence was found to have a significant relationship in the research findings (Dahlqvist et al., 2007).

### **Stress of Conscience**

Following one’s voice of conscience honors an established sense of moral integrity. This can be threatened by a troubled conscience which results from acting against personal beliefs. Continued exploration into issues which constitute a troubled

conscience has led additional researchers to investigate the potential outcomes associated with perceived stressors in the workplace. Among these are Glasberg et al. (2006) whose aim was to assess stressful healthcare situations that could cause a troubled conscience and to examine the degree of troubled conscience that arises from certain situations. The term “stress of conscience” was utilized to refer to stress induced by a troubled conscience. This could be associated with multiple issues due to an involved dissonance between person and society (such as the community that works together on a nursing unit), or person and person, and also within the self (Ahlin et al., 2012). As an example, a stress of conscience might occur when a nurse believes an organizational constraint prevents the ability to provide good patient care. The constraint causes a conflict of conscience within the nurse due to a perceived compromise in the nurse’s values and integrity by not meeting the patient’s needs. The inability to follow what Glasberg et al. (2006) referred to as an inner voice results in a stress of conscience. This experience can be perceived as a consequence of failure to attain what the inner voice expects or demands (Ahlin et al., 2012).

The researchers found that the extent and frequency of a troubled conscience caused by an ethically stressful situation could be measured through the ratings provided by the health team members. By integrating evidence obtained from an extensive literature review which identified different possible stress sources contributing to troubled conscience, the Stress of Conscience Questionnaire was created (Glasberg et al., 2006). The instrument is based on the perceived experiences of stress based on a conflict between the healthcare personnel’s ethical beliefs about right and wrong, or good and bad, and their basic values. It has also been used in other industries such as studying

stress of conscience in police personnel (Backteman-Erlanson, 2013). However, the majority of research refers to situations where health providers are unable to fully address the needs or challenges of those receiving care. Of those studies, only a few international research studies have examined the general role of stress of conscience in nurses in the hospital acute care setting (Ahlin et al., 2012; Glasberg et al., 2006; Glasberg, Eriksson, & Norberg, 2007; Glasberg et al., 2008; Gustafsson et al., 2010; Jensen & Liddell, 2009; Tuveesson et al., 2012; Tuveesson & Eklund, 2014).

Researchers have found that one of the more frequent reasons nurses report a stress of conscience is due to lack of time. Incompatible work demands, completing necessary patient tasks and ensuring quality care delivery underlie nurses' concerns that an inadequate amount of time exists to meet such expectations (Alkrisat, 2011; Glasberg et al., 2007; Saarnio et al., 2012). Unlike the ward or unit atmosphere which focuses primarily on treatment and patient care, the psychosocial work environment stresses organizational conditions for the nurses in their work and in their relationships with other staff and managers (Tuveesson et al., 2012). The inability to meet others' expectations and having very demanding work which influences home life have been shown to be statistically significant for stress of conscience and have a positive relationship with emotional exhaustion (Glasberg et al., 2007; Saarnio et al., 2012).

The relationship of moral integrity and stress of conscience has been studied to better understand possible influences on ethical decision-making in the nursing profession (Tuveesson et al., 2012). Moral sensitivity has been described by Lutzen, Dahlqvist, Eriksson, and Norberg (2006) as the attention to the moral values arising in a conflict-laden situation and an awareness of one's own role and responsibility in the

conflict situation. The authors state that personal experience allows one to sense a situation's moral significance through personal capacity and does not necessarily rely on emotions alone for moral conflict identification (Lutzen et al., 2006). Previous findings from Juthberg et al. (2008) suggested that a violation of one's conscience may cause a loss of wholeness and integrity, resulting in disharmony in the self, ultimately causing a feeling of lower personal accomplishment. Rushton and Kurtz (2015) contend that without the skills to locate the source of one's moral discontent, it is difficult to devise effective means of addressing it. They note a lack of moral sensitivity can also contribute to nurses' tolerating situations that are ethically unjustified. Over time, such situations can become normalized, and nurses no longer recognize what is at stake (Rushton & Kurtz, 2015).

Turesson et al. (2012) refined the scientific inquiry into this concept by investigating the influences of perceived stress and moral integrity on stress of conscience. The researchers examined potential differences among registered nurses and nursing assistants working in the in-patient psychiatric wards in hospitals in Sweden. Findings revealed that higher levels of moral sensitivity predicted moral stress in the nursing staff. A supportive environment was critical to enable nursing staff to follow their moral agency in the workplace and give attention to their moral sensitivity. Interestingly, a unique aspect of a supportive environment in this study involved the nurse's ability to have control over the work environment. When nurses perceived they possessed more control in their work setting, stress of conscience was reportedly lower than those who expressed having decreased control (Turesson et al., 2012). This is consistent with Lutzen, Cronqvist, Magnusson, and Andersson (2003) who found that moral stress is

more likely to occur when staff members are morally sensitive to patient care but do not have control over the decisions. When these factors remain unresolved, moral distress is likely the result (Rushton & Kurtz, 2015).

### **Perceptions of Conscience and Stress of Conscience**

Members of the nursing profession have attempted to examine perceptions of conscience and stress of conscience by integrating the concepts for further research and by using both of the respective instruments in single studies. Understanding the influence that these concepts have on burnout in nurses has been a particular focus. Maslach and Jackson (1981) first conceptualized burnout as a syndrome that has the three components. The first is emotional exhaustion which refers to a mental and physical tension and strain from job-related stressors. Depersonalization, the second concept, is the distancing of oneself from others and viewing others impersonally. The third is diminished personal accomplishment which is explained as a feeling of negative self-evaluation (Maslach & Jackson, 1981).

Previous findings support that emotional exhaustion, depersonalization and also having to deaden one's conscience to work in healthcare are positively related to stress of conscience and burnout (Ahlin et al., 2013; Ericson-Lidman et al., 2015; Glasberg et al., 2008; Gustafson et al., 2010; Juthberg et al., 2008; Juthberg et al., 2010). Deadening one's conscience may have several meanings, such as to collaborate at any cost with other health professionals, to place higher priority on a colleague's opinion instead of paying attention to the inner dictate of one's own voice or to uphold one's identity to other team members as being a "good" healthcare professional. These aspects may also be related to the nurse's desire to assimilate with other staff in the work environment.

This was supported by Ham's (2004) study, which revealed a negative relationship between principled thinking and number of years of nursing experience. Specifically, senior nursing students showed higher-level principled thinking than did experienced nurses. Ham postulated that new graduate nurses discard personal beliefs of right and wrong and place higher priority on adapting into the professional work environment. The potential risk in this is masking one's own inner directives. Kelly (1998) found that moral distress resulted within two years of practice due to reports by nurses that adjusting to their professional role caused a loss of personal standards. This alludes to what Juthberg et al. (2007) call a dissonance between a normative perception (what conscience in general is, what one should do) and a perception referring directly to the person (what I do and my conscience).

In Gustafson et al. (2010), the results showed the participants with higher levels of burnout and stress of conscience reported that the perception of conscience was a burden and that their conscience dissipates if they do not listen to it. Moreover, the staff reporting burnout also thought their conscience was far too strict and that they had to deaden it when unable to live up to their own standards. By comparison, findings revealed the non-burnout group had lower levels of stress of conscience which correlated with their perceptions of conscience as a being both a guide and an asset that cannot be avoided; thus, it helps them to provide good care. Gustafson et al. (2010) summarized their findings by describing that conscience is both an asset and a burden. By sharing burdensome work experiences with coworkers and superiors in a tolerant atmosphere, the researchers contend that a reduction in stress of conscience and burnout may result from an awareness of what constitutes reasonable demands and goals in daily practice.

## **Summary of the Critical Literature**

A review of the critical literature reveals several important findings and offers support for this study. Organizational climates involve multiple types of environments and cultures and can vary widely between departments within an organization (Malloy et al., 2009; Schneider, 1983; Stone et al., 2005). Ethical climates are viewed as sub-climates within an organization (Victor & Cullen, 1988). Management teams play a significant role in contributing to and maintaining the climates within the organization (Brown & Brooks, 2002; Watson et al., 2008).

Hospital ethical climates reflect shared moral values among healthcare team members as defined by each discipline's professional code of ethics (Fowler, 2015; Kelly, 1996; Olson, 1995). The ethical climate of a hospital has been found to influence the nurses' decision to stay or leave an employer and/or the nursing profession (Chambers, 1990; Han, 2014; Hwang & Park, 2014; Stichler, 1990; Ulrich & Soeken, 2005). Studies have also shown that the hospital ethical climate may contribute to moral distress and burnout among nurses in the work setting (Atabay et al., 2015; Gutierrez, 2005; Hamric & Blackhall, 2007; Lutzen et al., 2010; Wadensten et al., 2009; Wilkinson, 1987).

Additionally, several definitions of conscience were found to exist in the literature with religious, sociological and psychological influences represented throughout history (Benjamin, 1995; Birchley, 2012; Cook, 2007; Genuis & Lipp, 2013; Kohlberg, 1997; Kukla, 2002; Morton & Kirkwood, 2009; Orr, 2010; Wurgaft, 1996). Perceptions of conscience has been studied among nurses and can be viewed as an asset or burden in ethical decision making during difficult patient care decisions (Dahlqvist et al., 2007;



Kelly, 1998; Torjuul et al., 2005). Stress of conscience has been found to occur in nurses due to a compromise in personal integrity related to an inability to meet the demands of patient care needs (Glasberg et al., 2007; Lutzen et al., 2003; Tuvevsson et al., 2012). Other findings reveal that stress of conscience in nurses is positively related to burnout, and disengagement (Ahlin et al., 2013; Ericson-Lidman et al., 2015; Glasberg et al., 2008; Gustafsson et al., 2010; Juthberg et al., 2008; Juthberg et al., 2010).

During the literature review a gap in knowledge was identified regarding the relationship between hospital ethical climate and the role of conscience among nurses, providing an opportunity for additional study. Various theories were also examined as these are important to use to explain, describe and predict phenomena under investigation (Tomey & Alligood, 1998). Two theories were identified and selected to assist and guide this research study.

### **Theoretical Framework**

Nursing researchers conduct scholarly inquiry through the a theoretical lens. For this study, two models were used to investigate the variables of ethical climate, perceptions of conscience and stress of conscience. The ethical climate theory (Victor & Cullen, 1988) and moral distress theory (Jameton, 1984; Corley, 2002) both served for systematic exploration of possible relationships between the variables.

#### **Ethical Climate Theory**

The framework of ethical climate theory was influenced by Kohlberg's philosophical constructs of moral development. He believed throughout a person's lifespan, various approaches to ethical criteria are used. Over time, transitional moral reasoning types are demonstrated by the individual (Kohlberg, 1984). The notion that one

has free will to connect and reference an inner belief system served as a unique and important platform to Kohlberg's theory. Similar to other psychological theories, he believed that a person moved through multiple sequential stages as part of the development process. This could be identified from the initial stage of being fearful of retribution or even punishment to becoming aware of others and feeling concern. Kohlberg contended that through moral maturation experience, the person would support the needs of humanity and recognize the importance of universal rights (Kohlberg, 1984). He described self-interest, caring and principle as three key values in the progression of the person. These have been associated with the ethical constructs of egoism, utilitarianism and deontology (Cullen, Victor, & Bronson, 1993; Fritzche & Becker, 1984; Victor & Cullen, 1988; Williams, 1985)

The idea that individuals bring a set of values based on their moral development and how this might influence the organizational setting piqued the interest of several researchers. Ethical decision-making created a roadmap for scientific investigation of actions that occur within the work environment. Victor and Cullen (1987) proposed the ethical climate theory and hypothesized that an individual's behavior fosters an ethical climate in the organization by means of the group socialization process. The behavioral interactions among the employees contribute to and sustain the ethical climate (Victor & Cullen, 1988) by responding to established cultural and sub-cultural norms (Cullen et al., 1993; Hackman, 1976; Mulki, Jaramillo, & Locander, 2008). Further, the observation that sub-cultures within the organization could have differing belief systems and ethical environments were considered to be typical (Victor & Cullen, 1988). Previous studies

have confirmed that one major condition will prevail in the organization which will establish the parameters of the organization's ethical climate (Martin & Cullen, 2006).

In their proposed theory, Victor and Cullen (1988) contended that a person's history and the background of an organization blend and serve as a key element of ethical climate. They also found that it was possible for employees to hold similar ethical perspectives even though their related job functions were varied. Much of this could be contingent upon the temperament of the organization's departments and the context of the perceived ethical climate (Victor & Cullen, 1988). Over the past 30 years, the ethical climate theory has been utilized extensively in research across multiple industries, including nursing (Joseph & Deshpande, 1997), and has demonstrated positive relationships between ethical climate and several types of outcomes (Martin & Cullen, 2006).

The conceptual model for the ethical climate theory was the result of original research conducted by Victor and Cullen. They examined the relationships of differing ethical climates which focused on two perspectives. The first involved elements used by a person to complete ethical decisions. These decisions could include benevolence, egoism, or principlism. The factors associated with locus of control for making decisions was the second perspective. A person could base such ethical decisions on individual, peer-based, or the larger societal rationale or influence. Victor and Cullen (1988) found that these perspectives were intertwined in unique ways for various types of organizations and this led to varying criteria sets related to the formation of moral judgment within the workplace. Their findings revealed nine potential ethical climates, but after additional investigation, they reduced these to five by scientific confirmation. Additional research

has confirmed this validity (Martin & Cullen, 2006). Thus, the accepted five ethical climates of Victor and Cullen's (1988) ethical climate theory are caring, rules, law and code, independence and instrumental. It has been argued that these tend to guide the ethical conduct as staff usually desire to demonstrate professional actions in the workplace that are consistent with established organizational values (Grojean, Resick, Dickson, & Smith, 2004).

The ethical climate of caring is a construct that stems from the benevolence conceptual model and from utilitarianism. Martin and Cullen (2006) stated that caring, as an applied concept, means that individuals believe that the decisions made within the organization should emanate from the priority of concern that employees and management possess for one another. Further this concerns extends beyond the organization to the larger community it serves and to society (Martin & Cullen, 2006). In the nursing, caring is considered to be the primary cornerstone of the profession. Jean Watson, a prominent nursing theorist, has committed significant research over the past 40 years in the area of caring science. Her work adds to the Victor and Cullen (1988) model based on her own theoretical assumptions. Among these assumptions is that a caring environment is nurse (or employee) led and allows the person to choose the best action given moment at any given moment (Watson, 1979). She stated that caring for one's self and having inner peace is a prerequisite to caring for others and it is this that promotes a positive, caring environment (Watson, 1988).

The second type of ethical climate involves rules which are associated with established procedures and behavioral expectations set forth by the organization. In the healthcare industry, these rules may be driven by regulatory guidelines, standard of

practice, ethical codes and licensure requirements (Black, 2014; Catalano, 2015).

Although viewed as being external to the organization in some industries, these rules serve as the primary mechanism for which patient safety and quality are ensured in healthcare. Essentially, all team members are expected to conform to these rules and by doing so, this contributes to a positive ethical environment (Victor & Cullen, 1988).

Similarly, law and code is the third type of ethical climate and this assumption is centered on the belief that the following of laws and regulations is supported by the organization.

Thus, decisions are implemented by employees in effect to be compliant with both legal requirements and professional codes of conduct (Martin & Cullen, 2006). Adherence to these expectations supports the ethical environment for the staff. However, Fowler (2015) points out noncompliance can be serious in nursing. She states that when nurses believe that their integrity is placed at risk as a result of poor institutional conduct either by an implicit or explicit practice violation; they must speak about their concerns either individually or collectively to the appropriate counsel or authority. Failure to speak erodes the essence of the ethical environment under which nurses are employed (Fowler, 2015).

The fourth type of ethical climate according to Victor and Cullen (1988) is instrumental. This is fostered from an individualistic perspective that bases decisions driven by an egoistic approach. The potential jeopardy in an instrumental climate is one's self-interest is viewed as more important than others within the organization, even to employee's detriment (Cullen & Martin, 2006). Such dysfunctional behavior by employees creates a negative ethical climate and may lead to several consequences for the organization such as staff turnover or litigation. This type of climate has been

reported as the least preferred in studies (Flannery & May, 2000; Cullen & Martin, 2006; Victor & Cullen, 1988).

The independence climate is the fifth perspective in the ethical climate theory. This type holds that employees connect their actions to their devout moral beliefs for ethical decisions. These individuals deem that organizational choices to address ethical dilemmas involve moral consequences without significant regard to external sources of influence (Martin & Cullen, 2006). At the heart of this ethical climate type is one's personal morality, which is also affected by the principle climate.

In general, the climate types proposed by Victor and Cullen (1998) can be demonstrated in the hospital setting and may be visible among nurses in the work setting. The significance of nurses caring for one another by sharing the work burdens of patient care and staffing issues produces a positive work environment. In a meta-analysis of the literature, Martin and Cullen (2006) have noted a few general findings regarding the ethical climate theory. First, external regulations and rules, including professional codes of conduct, suggest positive organizational outcomes when these are implemented and followed as the norm within the work setting. Second, they found from previous research studies that the law and code, caring, rules and independence ethical climates appear to decrease misbehaviors in the organization. However, even when employees respect the established rules climate as the primary environment of influence, organizational commitment is unlikely (Martin & Cullen, 2006). Finally, the concepts utilized to describe the ethical climate setting can be applied to study a wide variety of work settings, including healthcare (Cullen et al., 1993; Martin & Cullen, 2006).

## **Moral Distress Theory**

The concept of moral distress theory first originated in nursing when Jameton (1984) introduced it to describe nurses' inability to act on what they believed was right due to organizational constraints. The theoretical assumptions were built from a relativistic worldview (Hanna, 2004). Jameton (1984) described the internal disconcerting feelings nurses encounter as initial distress and defined moral distress as an emotion that surfaces within individuals when they are prohibited from acting on responsibilities which they believe to be morally correct. Wilkinson (1988) added to the definition of moral distress by describing the unsettling feelings nurses experience as a psychological imbalance and negative emotional state that prevent the ability to perform tasks that are morally expected. This obstacle then causes the nurse to mentally wrestle with a perceived ethical dilemma against an external constraint that, unless resolved, transitions from moral stress to moral distress (Jameton, 1984; Wilkinson, 1988).

With organizational constraints, the nurse may struggle with the right course of action because some decisions extend beyond the nurse's control (Woods, 2014). The ethical climate can contribute to how the constraint may be perceived by nurses and will become evident in how the organization treats patients and staff, establishes goals and handles conflicts (Corley, Minick, & Elswick, 2005). It provides a background for professional nursing practice that influences various types of outcomes, including patient safety and the recruitment and retention of nurses (Pauly et al., 2009). Nurses may at times attempt to work around constraints to promote patient advocacy contingent upon the ethical environment in which they may work. However, additional challenges may also exist, such as poor leadership or lack of physician support, inadequate resources, regulatory

requirements and policy interference (Pauly et al., 2009). These and other factors influence the nurse's direct patient care activities.

Corley (2002) expanded upon Jameton's moral distress theory by clarifying the process which happens when a nurse is either unable or feels unable to advocate for a patient and thus experiences moral distress. She addresses the nurse's psychological responses to moral distress in the work environment and uses internal and external contexts as experienced by nurses. Corley built upon the terms "initial distress" and "reactive distress" in an effort to better distinguish the definitions for the nursing profession (Corley, 2002). Similar to Jameton (1984) and Wilkinson (1988), Corley (2002) believed that nurses working in a clinical environment are exposed to an elevated incidence of moral distress than those belonging to other professions because of the extreme situations in which they may work.

Corley (2002) explained that nursing has its foundation in ethical standards which are guided by the tenants associated with nurse practice acts, standards of practice and the professional code of ethics for nurses. Her assumptions include the view that nurses are moral agents and that nursing is a moral profession (Corley, 2002). Essentially, when nurses are prohibited to act on what they believe to be the right course of action, the use of moral agency is then disrupted. Several characteristics contribute to how the nurse will respond to an ethical dilemma in the work environment, and much of this is centered on the concept of moral competency which was originally described by Rest (1986). The theoretical constructs of nurse commitment, autonomy, moral sensitivity, judgment, perceptions of conflict, sense-making, and certainty are interrelated with moral competency (Corley, 2002; Rest, 1986), and these, in addition to the nurse's own value



system, will determine the nurse's decision to act. However, if the nurse chooses not to proceed due to perceived organizational constraints, then the resulting consequence may lead to moral distress. Nurses experiencing moral distress may feel that their integrity and authenticity are being undermined (Beumer, 2008). It was Corley's (2002) contention that moral distress and its attendant feelings, including vulnerability and outrage, may negatively affect nurses' abilities to care for patients even before burnout symptoms appear or they elect to separate from their employers or leave the nursing profession. The moral distress theory predicts implications for a healthcare organization could mean increased nurse turnover, decreased quality in patient care, and poor patient satisfaction rates, and that these consequences can impact recruiting, reputation, and accreditation (Corley, 2002).

This theory provides a framework for the organizational perspective to be considered for this study and how ethical climate may be interrelated. Within the context of healthcare organizations, it has been proposed that decreased levels of stress of conscience and moral distress are present when nurses are influential in their work settings and are more likely to be involved in active resolution of a dilemma (Dahlqvist et al., 2006; Penticuff & Walden, 2000); have high levels of ethics work satisfaction (McDaniel, 1995); have positive relationships with peers, patients, managers, physicians, and administration (Olson, 1998); and work in institutions that have policies that guide practice (Han, 2014; Hutchinson, 1990). From the organizational perspective, these propositions reflect the external context—the work environment—of the moral distress theoretical model.

## **Identifying the Gap**

Despite the interest in understanding the impact of ethical dilemmas and factors that pose challenges for healthcare staff across multiple disciplines, few studies have examined the intrinsic factors which may affect registered nurses in their work settings (Pauly et al., 2009; Schluter et al., 2008). Within the nursing field, a thorough review of the literature revealed several quantitative studies along with two mixed methods and one qualitative study which examined ethical climates in various nursing environments (Filipova, 2009; Hamric & Blackhall, 2007; Han, 2014; Hart, 2005; Hwang & Park, 2014; Numminen et al., 2014; Olson, 1998; Pauly et al., 2009; Silen et al., 2012; Suhonen et al., 2015; Whitehead et al., 2015). Most of these explored the relationship between ethical climate and such variables as intent to leave, job satisfaction, moral distress and burnout. While these external determinants yield important information about nurses' experiences and their intentions, research investigating how internal factors associated with moral sensitivity, personal values and perceptions of conscience are related to the ethical climate is lacking.

Other studies have examined the significance of conscience and the role it may play in relationship to stress of conscience in nurses. Yet these have been limited primarily to international settings, especially in Sweden where the initial research into conscience in health care settings began (Dahlqvist et al., 2006; Glasberg et al., 2006). Attention to potential differences between nurse specializations and work settings needs further examination (Glasberg et al., 2006). Cultural differences must also be explored further before results can be generalized to other countries where registered nurses are employed (Glasberg et al., 2006). Furthermore, studies of ethical climate within

organizations have not examined its relationship to conscience in the field of nursing and further investigation of such a relationship is warranted. The possible negative consequences of a troubled conscience make it imperative to understand more about situations that evoke it in order to offer guidance to personnel in how to relate to professional values and rules and to their personal conscience (Ahlin, Ericson-Lidman, Norberg, & Strandberg, 2013; Glasberg et al., 2006).

### **Bridging the Gap**

Until now, no studies have focused on the relationships among ethical climate, perceptions of conscience and stress of conscience in a health care setting. This study searched for correlations among these factors by performing an empirical analysis from the perspective of registered nurses working in the acute care hospital setting. This study was significant as it extended the research initiated by Olson (1998), Dahlqvist et al. (2006), and Glasberg et al. (2006). Olson's research into ethical climate established a positive correlation between work environments on employee outcomes and organizational effectiveness (Olson, 1998). The work by Dahlqvist et al. (2006) examined perceptions of conscience as an asset or burden among healthcare personnel, including physicians and nurses. Glasberg et al. (2006) studied factors that contributed to a troubled conscience and the frequency it could occur. However, the present research identified ethical climate characteristics associated with perceptions of conscience and the associated relationship to stress of conscience among registered nurses. It expanded upon existing research by examining the mediating impact of nurse specializations on the relationship between ethical climate, perceptions of conscience and stress of conscience.

## Chapter Summary

The literature reviewed in this chapter gave support for this research study. Organizational climate, culture and sub-climates were discussed and findings from previous studies were analyzed. The concept of ethical climate and its importance in the health care organization was highlighted and possible implications were examined through the lens of nursing practice (Hamric & Blackhall, 2007; Olson, 1998; Pauly et al., 2009).. The role of conscience and its purposed use in ethical decision making was reviewed by discussing findings from previous research (Dahlqvist et al., 2007; Glasberg et al., 2007; Saarnio et al., 2012; Tuvevsson et al., 2012).. Specifically, the context of a troubled conscience provided meaning in relation to stress of conscience among health care personnel(Ahlin et al., 2013; Glasberg et al., 2007; Juthberg et al., 2007; Glasberg et al., 2008). The conceptual frameworks of Victor and Cullen's (1988) ethical climate theory and Corley's (2002) moral distress theory which were utilized to guide this study were analyzed based on the review of the literature.

Finally, the review in the chapter concluded with identification of the research literature gaps related to ethical climate, perceptions of conscience and stress of conscience among nursing professionals. Ethical climate in general is associated with favorable outcomes in the clinical environment (Joseph & Deshpande, 1997; Hart, 2005; Olson, 1998). Perceptions of conscience and stress of conscience have been positively correlated across several research studies in various health care settings (Ahlin et al., 2012; Ericson-Lidman & Ahlin, 2015; Glasberg et al., 2008; Gustafsson et al., 2010; Juthberg et al., 2007). This study bridges the gap in the scholarly nursing literature by identifying the relationship of ethical climate and the role of conscience defined more

closely through the lens of the hospital environment in a state in the southern United States. Additional analyses reveal the mediating impacts of nurse specializations in hospital settings on this relationship (Filipova, 2009; Han, 2014; Hwang & Park, 2014; Whitehead et al., 2015).

## **CHAPTER 3. METHODOLOGY**

### **Introduction**

The purpose of this chapter is to identify the methodology that was implemented in the execution of this study. The aim of this predictive correlational research was to determine if a positive relationship existed among ethical climate and perceptions of conscience on stress of conscience as perceived by registered nurses. The studies reviewed were critical in providing, theoretical, methodological, and instrumental foundations upon which this present study was developed and conducted.

The relationship of ethical climate, perceptions of conscience and stress of conscience had not been examined prior to this study. By understanding the influence of the independent variables upon the dependent variable and the interrelationships within this study, nurses will be better equipped to determine if ethical climate and issues of nursing conscience might influence a troubled conscience within their hospitals. This chapter describes the specific issues of research design, population and sample, procedures deployed for data collection, data analysis and limitations. The instruments used in this study are reviewed including information on reliability and validity.

Chapter 3 also describes the ethical assurances which were employed during the study. A special emphasis was placed on procedures taken to safeguard the privacy of the participants following ethical research guidelines and standards. Because the study participants were likely to reflect on work situations that cause a troubled conscience, it was particularly important to ensure that ethical standards were maintained in the study. Among the measures implemented were informed consent, voluntary participation and

withdrawal from the study, coding of the data with alphanumeric identifies rather than participant names, and the presentation of the data in the aggregate.

### **Research Design**

Nursing practice evidence relies on descriptive, correlational, and experimental studies and the research design is the architectural backbone of the study (Polit & Beck, 2013). The role of the researcher's paradigm is also significant and for this study, a post-positivist approach was utilized. The association of quantitative designs tends to be invoked in the worldview of post-positivists since there is a strong belief that the social and natural world can be understood when a specific scientific method is applied (Creswell, 2012). Thus, a quantitative, non-experimental, descriptive correlational study was selected. The research problem for this study addressed the issue on how nurses' perceptions of ethical climate and their beliefs about the role of individual conscience relates to a stress of conscience in the hospital. This design was best suited to quantify the strengths of relationships among variables, identify patterns, make predictions, use numeric values and statistical analyses (Bordens & Abbott, 2008; Creswell, 2014; Polit & Beck, 2012).

Studies to understand nurses' roles and experiences are important to promote quality outcomes in the nursing profession and the healthcare system (Doran, 2011). However, there is not enough research to date describing the perceptions of conscience, mechanisms, or relationships of ethical climate to stress of conscience (Dahlqvist et al., 2007; Glasberg et al., 2007; Gustafsson et al., 2010; Numminen et al., 2015). With a quantitative research focus, the aim was to determine what, if any, statistical relationship existed between ethical climate, perceptions of conscience, and stress of conscience

among registered nurses working in acute hospitals. Utilizing this methodological approach stemmed from the intent to create a systematic design where comparable data can be produced through the examination of relationships among variables.

Documentation of behaviors intensity has value in descriptive studies and is greatly needed to develop successful interventions (Polit & Beck, 2012). The design allowed for responses to be gathered from a large number of registered nurses practicing in a variety of hospitals in the state of Louisiana which included for profit, non-profit, governmental, and specialty acute hospitals.

Describing the nature of relationships between variables instead of supporting causality assumptions is the intent of descriptive correlational research (Polit & Beck, 2012). Correlational studies allow for exploration of two or more variables and how they influence each other as well as the dependent variable (Creswell, 2012). Another important role of a correlational design is to define the direction and strength of the relationships among variables according to previous research findings (Grove, Burns, & Gray, 2013; Wood & Ross-Kerr, 2011). The proposed relationships in this study were based on suggested evidence from prior nursing research which supported the belief that a relationship may exist between the variables. This is similar to comparative designs because there is no manipulation, and valid and reliable variables measurements provided from previous research literature are necessary (Wood & Ross-Kerr, 2011). Two conceptual frameworks, Victor and Cullen's Ethical Climate Theory and Corley's Moral Distress Theory, were utilized to identify a gap in the research and served as the models to test the hypotheses among the variables in this study. In a correlational design, analyses examine variable values in the entire sample as a single group (Grove, 2007;



Grove, Burns, & Gray, 2013; Kerlinger & Lee, 2000). It involves a one-time data collection process, or the phenomena being investigated are analyzed over a data collection period of time (Polit & Beck, 2012).

There are limitations which are associated with non-experimental, correlational research. First, according to Polit and Beck (2012), a researcher conducting this type of study should not assume that a similarity exists between comparison groups before the occurrence of the hypothesized cause or the independent variable. In the realm of nursing, dealing with multiple patients with many diagnoses types is fluid and ever changing. Decision-based interactions with other nurse and physician colleagues are a dynamic process with numerous communications occurring daily. Second, in reality, attitudes, behaviors, and characteristics possess an interrelated complexity which creates challenges for the interpretation of correlational findings (Polit & Beck, 2012). Thus, each nursing department within a hospital may have its own distinct environment and is affected by staffing patterns, specializations associated with particular units, and the individualized needs of each patient. Subjects differ on many factors, only a few which can be controlled (Wood & Ross-Kerr, 2011). It can be difficult to determine how these relationships may evolve over time, which limits researcher predictability. Third, unlike experimental studies, variables of interest in non-experimental studies lack manipulation and randomization in the sampling procedures. Therefore, these types of studies do not allow for causal inferences to be made (Polit & Beck, 2012). A fourth limitation is that alternative explanations can be possible in descriptive surveys and results should be considered tentative (Tappen, 2016; Wood & Ross-Kerr, 2011)

However, there are also several strengths of correlational research. For example, sometimes, due to the specific variables of interest, nursing problems identified in clinical practice cannot always be studied using an experimental design. Because certain clinical problems in nursing research are not able to undergo scientific experimentation, correlational research provides an additional option for investigation (Polit & Beck, 2012). In certain cases, it is not possible to manipulate variables for experimental purposes, or to do so outside of the natural environment would not provide answers or meaning (Wood & Ross-Kerr, 2011). An additional strength of correlational research is there is an opportunity to collect a large amount of data about a problem (Polit & Beck, 2012). This provides the researcher the ability to determine the strength and direction of the relationships of the variables being studied. Finally, although correlational studies capture a situation in time, the studies provide the groundwork for additional investigation through future research for other scholars (Tappen, 2016).

The independent variables in this research study were hospital ethical climate and perceptions of conscience. The dependent variable was stress of conscience as this may be affected by the existing work conditions and climate on a particular nursing unit within the hospital setting. The existence of multiple independent variables made a correlational strategy of inquiry suitable for examining the independent variables affecting stress of conscience in nurses working in hospitals. This study observed the variables without manipulating them as would occur in an experiment (Bordens & Abbott, 2010). For reasons of feasibility, these multiple independent variables are best explored in a correlational versus a causal strategy of inquiry (Creswell, 2012). This design was appropriate for the present study so that the variables of ethical climate and

conscience as perceived by nurses in their own work settings could be investigated. Correlational designs are often strong in realism (Polit & Beck, 2012).

A descriptive survey research design can be of great value when investigating opinions, attitudes, or beliefs from subjects (Wood & Ross-Kerr, 2011). This study utilized three published and standardized surveys that collected data on each of the identified variables including perceptions of ethical climate and beliefs about the role of conscience in the acute care setting. The survey was provided to a purposive, non-probability sample of registered nurses throughout Louisiana using an online web-based survey format. This provided an opportunity to reach a larger sample of nurses. All participants completed a demographic survey. These nurses were selected as having met the inclusion criteria for employment at an acute hospital working as front line staff providing patient care. The survey data was coded numerically allowing for a quantitative method of data analysis, such as statistical analyses to examine correlational relationships (Tappen, 2016).

### **Population/Sample**

The identified population for this study was registered nurses within the state of Louisiana who provided direct care to patients, family members and significant others in the acute hospital setting. According to the Louisiana State Board of Nursing (2014), there are approximately 55,000 nurses holding a RN license residing in Louisiana. Of those, nearly 19,000 work in the acute care setting or hospital environment (LSBN, 2014). The practicing nurse population was obtained through a combination of purposeful and non-proportional stratified sampling. Using this method created the potential for a larger sample size, as well as a higher level of generalizability (Polit & Beck, 2012).

The state of Louisiana was chosen for several reasons. First, empirical research on nurse attitudes regarding ethical conditions involving the hospital ethical climate and use of conscience in the United States is limited (Jensen, 2009; Laabs, 2011) and the findings from this study may contribute significant scientific knowledge to the nursing profession. Second, a variety of private, state government and Veteran's Affairs hospitals exist throughout the state in a number of varied socioeconomic and geographic areas (Louisiana Hospital Association, 2015). Third, there is a familiarity with many of the facilities in the state, and it is also this researcher's state of residence.

The research design involved a single stage purposive, non-probability sampling procedure. With this design, objectivity for subject selection can be planned by the researcher (Wood & Ross-Kerr, 2011). A randomized sample list of candidates was purchased from the Louisiana State Board of Nursing (LSBN) which was used as the source for potential survey participants. The LSBN has developed a program to assist researchers to determine which nurses meet the defined criteria for various studies. Out of a possible list of over 55,000 registered nurses in Louisiana, the names and addresses of 650 nurses who met specified criteria were generated, screened and verified by the LSBN from the state database list of active registered nurses by stratified sampling. Based on the provided randomized list by the LSBN, this model of sampling identified the target population free from researcher bias. By selecting nurses that met defined parameters, there were fewer wasted resources since surveys would not be mailed to nurses who were not of interest to this study.

The research focus was on staff nurses engaged in direct patient care in an acute care hospital as opposed to nurse managers or advanced practice nurses who may

experience the ethical environment and role of conscience differently. Sufficient time spent with patients each week and minimum length of time to become exposed to the issues related to the nursing unit, familiarity with other healthcare team members and the specific institutional work environment were deemed necessary for accurate responses to the questions posed in the instruments. Potential subjects were considered eligible if they were registered nurses with active licenses for more than one year, employed in clinical settings for more than six months and were willing to complete the survey. Licensed practical/vocational nurses were excluded. Agency nurses and traveling or contract nurses were also excluded because their employers were not the actual hospital organization. As contractors, their exposure to the hospital facility is usually limited to a few shifts so integrated experience with the ethical climate will not be fully developed.

The size of the sample was considered fundamental in order to ensure an adequate sampling. When planning for a quantitative research sample, size and representativeness are two important considerations (Polit & Beck, 2012). Since the instruments had not been previously paired to detect a significant relationship, the effect size for determining the sample size is moderate or medium (Cohen, 1988). For a statistical power of 0.95 and a medium effect size at 0.15, the sample size for an alpha at the 0.05 level of significance was a minimum of 106 nurse participants. The total number of valid survey responses was 193, many more than the needed minimum sample size. Based on review of previous studies (Glasberg et al., 2006; Gustafsson, Eriksson, Strandberg, & Norberg, 2010; Lutzen et al., 2010; Tuveson, Eklund, & Wann-Hansson, 2012; Tuveson & Eklund, 2014), there was confidence the method to determine sample size provided an adequate representation of the total registered nurse population within the state of Louisiana.

Through the stratified list of registered nurses generated by the LSBN, 650 sample participants were identified and contacted by mail for participation in a web-based survey. The request included an explanation of the study, the potential value of the study to the nursing science field, the estimated length of time needed to complete the surveys, and information related to participant confidentiality. Nurses who agreed to participate in the study were directed to a secure webpage at [www.surveymonkey.com](http://www.surveymonkey.com), which is an Internet-based commercial survey service. After logging on, each participant completed an electronic version of the demographic questionnaire, the Ethical Climate Survey, the Perceptions of Conscience Questionnaire and the Stress of Conscience Questionnaire. All completed survey responses are included in the aggregate data for analysis. Partial surveys, which are those where respondents began the survey but opted out after starting the survey, were excluded.

The response rate was a priority since participants were contacted by the U.S. mail system. Each respondent received a letter invitation and a follow-up reminder letter was sent after 14 days. Similar to other members of the health professions, survey response rates by nurse participants has declined in recent years (Hill, Fahrney, Wheelless, & Carson, 2006; Ulrich & Grady, 2004; Im & Chee, 2001) and may be below 50% (Cook, Dickinson, & Eccles, 2009). No financial incentive was offered for participation. A conservative response rate was assumed at 20% in order to obtain at least 120 nurse participants in the study and to account for those who did not complete the entire survey. Online participants received an electronic acknowledgement upon completion of their surveys. Based on the number of respondents who completed this survey, the response rate was 30%.

## **Setting**

The researcher drew a sample of registered nurse participants from a list provided by the Louisiana State Board of Nursing (LSBN). The sample list contained the home address and parish of residence for each respondent. All parishes throughout the state were represented. A physical location was not needed. The participants were contacted directly through the mail and the researcher did not visit any hospitals or conduct on site research within the parishes. The research study was conducted via internet using a commercial online survey service. The contacted individuals provided consent to participate in the study prior to the completion and submission of the online survey. The research setting was the virtual online space of the Survey Monkey webpage. The subjects chose the physical setting for accessing the internet to participate in the study and were not asked to indicate their physical location during survey completion.

## **Instrumentation and Measures**

This research study utilized instruments that have been used in past research with demonstrated validity and reliability to provide a robust test of the hypotheses. The measures in the present research focused on ethical climate, perceptions of conscience, and stress of conscience. The respondents were first asked for demographic information which was based on information provided by Olson (1995). The information consisted of gender, age, race, highest level of education obtained, years of nursing experience, years at the present employer, number of weekly hours worked, type of shift worked, bed size of the hospital facility, clinical department in which they were employed, and religious preference. The instrument was a questionnaire made up of 60 items covering the areas of ethical climate and conscience and was a combination of three scales: the Hospital

Ethical Climate Survey, the Perceptions of Conscience Questionnaire, and the Stress of Conscience Questionnaire. Each scale is an established survey instrument that has been previously tested and yielded scores with acceptable reliability and validity. A Cronbach's alpha will be reported for this study on each of the scales in the next chapter.

The first independent variable, ethical climate, was studied using the Hospital Ethical Climate Survey (HECS) which was designed by Olson (1995) to examine nurses' ethical climate perceptions of the hospital work environment. The instrument was guided and designed according to organizational climate types and ethical reflection conditions (Numminen et al., 2015; Olson, 1998). There are 26 questions which depict organizational routines that allow nurses to relate to ethical workplace situations where difficult patient care issues or other dilemmas might occur (Suhonen et al., 2015). Therefore, in the present study, the participants were asked to complete the survey based on current environment conditions and not on what they might prefer or wish for their work setting.

The items are composed of five subscales: peers (four items), patients (four items), managers (six items), hospital (six items), and physicians (six items). The subscales allow for the identification of organizational interventions to assess and advance the ethical climate, but are not meant to stand alone (Suhonen et al., 2015). The HECS instructs participants to select the most suitable alternative on a five-point Likert scale ranging from 1 to 5 (from 1 = almost never true to 5 = almost always true) with a calculation of the total score. Higher values indicate a positive, favorable ethical climate (Ghorbani et al., 2014; Han, 2014; Olson, 1995; Suhonen et al., 2015). A confirmatory factor analysis to determine the validity of the scale and the goodness of the fit of the



final model was cited as 0.95 (Olson, 1995). The Cronbach's alpha for this scale has been demonstrated at 0.92 (Olson, 1998), 0.85 (Lutzen et al., 2010) and 0.91 (Han, 2014) which indicates a strong relationship between the items and the variable being studied.

The second independent variable, perceptions of conscience, was measured using the Perceptions of Conscience Questionnaire (PCQ) which was designed and authenticated by Dahlqvist et al. (2007). The PCQ includes 16 statements which measure the importance of conscience (its significance, origin and function) among the respondents. The instrument considers six factors: conscience described as authority, a warning signal, demanding sensitivity, an asset, a burden, or depending on culture. Participants indicate their personal viewpoints on the statements on a 6-point Likert-type scale ranging from 'No, totally disagree' (1) to 'Yes, entirely agree' (6). The response scale format permits the answers to be dichotomized for objective description (Juthberg, Erickson, Norberg, & Sundin, 2010). Higher scores indicate increased importance. Factor analysis has shown that healthcare workers distinguish conscience as a warning signal, as an asset, an authority, as demanding sensitivity, or a burden and is dependent on cultural context (Ahlin et al., 2012). The Cronbach's alpha for this tool has been previously demonstrated between 0.64-0.70 (Ahlin et al., 2012; Dahlqvist et al., 2007; Juthberg et al., 2010).

The dependent variable for this study, stress of conscience, was measured by the Stress of Conscience Questionnaire (SCQ). The scale was developed and authenticated by Glasberg et al. (2006) and measures a troubled conscience as related to stress among healthcare personnel. Nine items are represented on the instrument with each item asking two questions, part A and part B. The first, part A, contains descriptions of ethical

difficult situations which differ in healthcare, for which respondents are asked to determine the situation frequency in their workplace. In part B, the respondents are asked to assess the extent to which the situations lead to a troubled conscience (Ericson-Lidman, & Ahlin, 2015). The part A and part B scores are multiplied for an item and the total stress of conscience item index is calculated. The total stress of conscience is calculated via the adding of each item's index for the overall scale (Juthberg et al., 2010). The part A responses are provided using a 6-point Likert-type scale: 'Never' (0), 'Less than once/6 months' (1), 'More than once/6 months' (2), 'Every month' (3), 'Every week' (4), and 'Every day' (5). The response scale for part B is a 10-cm visual analogue scale ranging from 'No, not at all' (0) a 'Yes, it gives me a very troubled conscience' (5). The index is then calculated for each question with higher points indicating a stress of conscience (Dahlqvist et al., 2007; Ahlin et al., 2007). The Cronbach's alpha for this tool has been previously demonstrated between 0.82-0.83 (Ahlin et al., 2012; Glasberg, Eriksson, & Dahlqvist, 2006; Juthberg et al., 2010).

### **Data Collection**

For this study, a minimum sample size of 120 registered nurses was required. After approval from the Capella Institutional Review Board (IRB), the researcher obtained permission from the LSBN to recruit study participants from their list of registered nurses with active licenses. The researcher purchased an initial mailing list of names which was randomized and verified by the LSBN Database Coordinator. Based on previous studies, a 20% response rate was anticipated. Therefore to obtain the desired sample size of at least 120 nurse participants, 650 invitations were sent out in the mail. An additional 200 participant names were also purchased in preparation for a possible

low response rate. It was planned that these would be utilized if the minimum number of respondents was not obtained from the initial list. The list of names provided in a Microsoft Excel spreadsheet was then sorted alphabetically by last name. The spreadsheet also contained the respondents' addresses and parish of residence.

The researcher mailed invitations to the addresses of the first 400 respondents. Each received the introductory letter and flyer in the mail detailing a description of the research, the survey web link, assurance of confidentiality, information regarding informed consent and an estimated time frame for completing the survey. One week later, an additional 250 invitations were mailed. After 3 weeks, over 100 surveys had been completed. A reminder letter was sent out during the fourth week. The data collection was completed in 6 weeks, during March to May, 2016. To improve the response rates, the following techniques were utilized:

1. The introduction letter explained that participants could contact the researcher directly for any questions and to receive a summary of the results.
2. Anonymity was discussed and the letter indicated a promise of confidentiality and privacy.
3. The data collection procedures were explained to indicate that the study was intended to obtain a statistically significant sample representing a state-wide nurse population.

Permission to use the instruments was obtained from authors. Each scale was recreated into a web-based survey, using the online tool SurveyMonkey.com, which is an Internet-based comprehensive survey service. This service has a 24-hour telephone line

that the subjects can also call as an alternative to completing the survey online, giving an option for those subjects who may not be comfortable with the Internet. A hardcopy survey with a self-addressed, stamped return envelope was initially planned to be mailed to those who indicate a preference for a mailed survey. However, no respondents chose these options and all surveys were completed online.

Respondents could agree to complete the survey during the 6 week period the study was conducted. At the survey website, respondents were first presented with an informed consent form, which had to be completed with a positive response to consent to participate. A negative response directed the respondents away from the survey and referred them to a thank you page. Negative responses to the informed consent were automatically deleted by the Survey Monkey tool. A statement provided to each respondent explained the available option to withdraw from the study at any time.

Once the respondent agreed to participate, the online survey process was initiated. First, demographic data on gender, age, ethnicity, educational levels, years of experience, hospital facility bed size, nurse specialization, hours worked per week, and religious preference was collected. The respondents were then surveyed to collect data on their perceptions of hospital ethical climate, perceptions of conscience and stress of conscience by completing the Hospital Ethical Climate Scale, the Perceptions of Conscience Questionnaire and the Stress of Conscience Questionnaire. To ensure anonymity, the surveys did not request names or any identifying numbers.

Once respondents answered the online survey, they had no more involvement in the study. The researcher's contact information was made available to any respondent who wanted to be informed of the study's results. However to date, no requests for

information have been received by the researcher. At the end of the survey collection period, a total of 193 responses were obtained.

### **Data Analysis**

The non-experimental quantitative study analyzed data utilizing descriptive and inferential statistics. With multiple variables, it is necessary to describe the relationship accordingly using quantitative measures and cross-tabulations (Martin & Bridgmon, 2012). There are common assumptions with each design that include: variables can be found in the population, variables are not manipulated and can be accurately measured on a numeric scale (Wood & Ross-Kerr, 2011). Demographic data contained both categorical and continuous questions that included gender, age, years of experience, nursing education levels, nurse specialization, hospital facility size and religious preference. Means and standard deviations were analyzed for continuous variables, and frequencies and percentages were used to summarize categorical variables. Correlations and regression analysis was used to explore research questions. Various Likert scales were used to assess hospital ethical climate, perceptions of conscience, and stress of conscience. The research questions were:

**RQ1:** What is the overall relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses in the acute care setting?

*H1o:* There is no relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses.

*H1a:* The relationship of hospital ethical climate and perceptions of conscience will be positively related to stress of conscience among registered nurses.

**RQ2:** What is the relationship between perceptions of conscience and stress of conscience among registered nurses?

*H2o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H2a:* There is a positive, significant relationship between perceptions of conscience and stress of conscience among registered nurses.

**RQ3:** What is the relationship between perceptions of conscience and hospital ethical climate among registered nurses?

*H3o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H3a:* There is a positive, significant relationship between perceptions of climate and hospital ethical climate among registered nurses.

**RQ4:** What is the relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse?

*H4o:* There is no significant relationship between hospital ethical climate and stress of conscience among registered nurses controlling for age, gender, specialization and number of years working as a nurse.

*H4a:* There is a positive, significant relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse.

**RQ5:** How do demographic factors and job characteristics influence stress of conscience among registered nurses?

*H5o*: There is no influence of demographic factors and job characteristics on stress of conscience among registered nurses.

*H5a*: There is an influence of demographic factors and job characteristics on stress of conscience among registered nurses.

**RQ6:** How does perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographic and job characteristics?

*H6o*: There is no difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

*H6a*: There is a difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

The statistical analyses were performed with the assistance of the Statistical Package for the Social Sciences (SPSS) software. Once coding of the survey data collected in SurveyMonkey.com was completed, the data was uploaded into the SPSS software, so the statistics analysis could be initiated. Diagnostics were performed to test the basic assumptions for linear multiple regression prior to data analysis. For the purposes of analysis, all missing values were coded as “-9” and deleted from the analysis, which is standard for the selected analytical software.

Frequency data or descriptive statistics (mean and standard deviation) were determined first to provide a graphic visual of the sample as well as any differences among groups of participants. The independent variables were entered in a stepwise

method in which the SPSS program selected and entered into the equation the variable with the highest bivariate correlation with each of the outcome variables. The reliability for scores on the instruments was determined by using Cronbach's alpha for internal consistency. This is a commonly used method of reliability testing (Grove et al., 2013) and the results were consistent with previous studies. The data were then examined using a predictive correlation analysis to identify possible relationships between individual variables.

Next, a linear regression analysis was conducted to determine the estimated highest possibility of a directional relationship between the dependent variable and each independent variable (Green & Salkind, 2007). A correlational matrix was then developed using the Pearson's  $r$  showing the strength of the relationships between the dependent variable and each of the independent variables (Polit & Beck, 2012). Through the use of a matrix, multiple correlation coefficients  $r$  and adjusted  $r^2$  were identified, which provided the proportion of variability accounted for by each independent variable. With multiple regressions, researchers typically ask inferential questions about relationships in the analysis which provides insight into causal analysis and it can assist with forecasting an effect and/or trend forecasting (Pedhazur, 1982; Polit & Beck, 2012). The analysis was tested at the .05 level of significance.

To answer the research questions proposed for this study, data were obtained for the independent variables ethical climate and perceptions of conscience by utilizing the Hospital Ethical Climate Survey and the Perceptions of Conscience Questionnaire. Data for the dependent variable, stress of conscience was obtained utilizing the Stress of Conscience Questionnaire. For the first research question concerning the overall



relationship of hospital ethical climate and perceptions of conscience on stress of conscience, a multiple regression, discriminant and canonical correlation analyses were utilized. Canonical analysis will generate linear combinations of variables to explain the maximum amount of covariance between the two sets of variables (Snyder & Mangrum, 2005).

To examine the predictive relationship of perceptions of conscience and stress of conscience for the second research question, a linear regression was conducted in addition to assessment using the absence of multicollinearity assumption. The third research question regarding the relationship between perceptions of conscience and hospital ethical climate, was examined by linear regression. The fourth research question examined the relationship between hospital ethical climate and stress of conscience among registered nurses and used a hierarchal linear regression was to control for the variables of age, gender, and number of years working as a nurse. For the fifth research question concerning how demographic factors and job characteristics influence stress of conscience among registered nurses, a multiple linear regression was utilized to examine the predictive relationship. A hierarchal regression was used for the sixth research question to analyze the overall model on how perceptions of conscience and ethical climate together influence stress of conscience above and beyond associated demographics and job characteristics. The control variables corresponded to gender, age, education, ethnicity, nurse experience, present hospital experience, hospital hours, work schedule, and number of hospital beds.

A check was done for violations of the regression assumptions including unusual and influential data points. The data were checked for homoscedasticity to determine if

any variability remained constant, and a normality of residuals or error was determined by a visual inspection of a histogram of the data. An evaluation of the descriptive statistics was conducted to identify the skewness (symmetry) and kurtosis of the data (peaks or flatness of the data) to identify the normality of residuals or how well the data fit the model. Chapter 4 includes a presentation and discussion of the results.

### **Ethical Considerations**

All researchers who utilize human subjects for study play an important role in ensuring ethical protections are safeguarded (Blais & Hayes, 2016). This study was reviewed and approved by the Capella University Institutional Review Board (IRB) before the research commenced. Prior to participation, respondents were provided a purpose description explaining the full scope and nature of the study. The researcher developed an informed consent form for respondents to read and sign before engaging in the research (Creswell, 2009). The electronic consent form was immediately visible as the first web page after each respondent logged in using the study's online link. This included an explanation on the methods and procedures to be employed, the risk and benefits, how the results would be used, and how confidentiality would be maintained. Primary considerations were given to the fundamental individual's autonomous choice to voluntarily participate. Nurse researchers conform to national and international ethical standards for research conduct involving human participants (American Nurses Association, 2015).

The measurement scales used in this research study included issues that were usually sources of potential stress in the clinical work setting. Respondents were assured that their information would be kept confidential and would not be shared by the

researcher. They were asked to report the perceptions of the hospital climate, their perceptions of conscience and consider factors in the work setting that might contribute to a stress of conscience. This might have resulted in emotions that were stressful to the respondents. All were assured that they could withdraw from the study at any time or refuse to participate. Respondents were provided with the researcher's contact information to direct any questions or request explanations for any concerns as needed. The researcher was willing to assist in locating employee assistance programs to support any respondent who reported experiencing distress while participating in the survey. However, no respondents contacted the researcher to report any adverse effects as a result of completing the survey.

The respondents were contacted by the researcher via mailed surveys as a result of a list of names and addresses that was purchased after approval was obtained from the Louisiana State Board of Nursing. However, this was the only instance of respondent identification in this study. The completed online surveys were numerically coded and aggregate data was utilized for analysis. The surveys, consent forms, coded data, and analysis were retained and stored throughout the duration of this study in a locked cabinet at the residence of the researcher to ensure all responses were kept confidential and anonymous. In accordance with the Capella University IRB policy, all study related data and information will be kept for 7 years after completion of the study, at which time all paperwork will be destroyed.

### **Chapter Summary**

This chapter describes the methodological model, research design, target population, instruments and measures to collect data, ethical considerations and provides

an overview of the data analyses that were implemented to study the research questions and hypotheses. A quantitative, non-experimental, correlational research design was utilized for this study. The target population was registered nurses in the state of Louisiana who work in acute hospitals and provide direct patient care. A sample of this population completed the Hospital Ethical Climate Survey, the Perceptions of Conscience Questionnaire and the Stress of Conscience Questionnaire. SPSS software was used to analyze the survey data to determine if significant relationships were found between ethical climate, perceptions of conscience and stress of conscience among nurses. The study adhered to all ethical requirements pursuant to Capella University IRB requirements. A detailed description of the analyses and an explanation of the research study results will be provided in Chapter 4.

## **CHAPTER 4. RESULTS**

### **Introduction**

The purpose of this study was to measure factors that affect registered nurses' beliefs and attitudes about hospital ethical climate and conscience in the acute care setting. This chapter presents the findings of the data collection process. A post-positivist approach was used as this philosophy provides a framework on events that affect the lives of individuals, both emotionally and socially. This paradigm permits the establishing of relationships among variables and these can be observed and measured quantitatively (Glicken, 2003; Mertens, 2005). The non-experimental, quantitative design utilized a purposive, non-probability sampling procedure with self-selecting voluntary participants. The survey was conducted online via the Survey Monkey website, which allowed for the creation of a webpage purposely for this research investigation. The use of this type of electronic survey platform provided a method of submitting responses anonymously.

The study examined the relationship between the hospital ethical climate where nurses spend their time each day, their perceptions of conscience and whether these variables may be related to stress of conscience. The level of this relationship was measured by individual registered nurses' responses to the Hospital Ethical Climate Survey, the Perceptions of Conscience Questionnaire, and the Stress of Conscience Questionnaire. Demographic data was also collected for additional analysis which included gender, highest education level obtained, employment status, hospital bed size, experience in years as a registered nurse, type of nursing unit/ward where employed, and religious preference.

The data were collected and entered into SPSS 22.0 and were first screened for missing responses and accuracy. Descriptive statistics were conducted for the sample through frequencies, percentages, means, and standard deviations. This provided a graphic visual of the sample as well as any differences among participants. A predictive correlational approach was used to analyze the information objectively and to identify possible relationships between individual variables. A reliability analysis was also performed on the scales for this study. Additionally, since multiple independent variables were used, regression analyses were performed to determine the existence of any statistically significant relationships (Creswell, 2012). Thus, statistical analyses for the research included a series of linear regressions and hierarchical linear regressions. Pearson's correlation coefficient was used to determine the degree to which the variables were related. Represented by the letter  $r$ , it is always between -1.00 and +1.00. A value of zero indicates no positive relationship between the two variables. If  $r$  presents as -1, a negative relationship is indicated between the variables being measured. However, if  $r$  is found as 1, there is a positive linear relationship between the variables (Grove et al., 2013). Significance for all inferential tests was evaluated at the generally accepted level,  $\alpha = .05$  which indicates a risk of rejecting the null hypothesis one time out of 20 (Polit & Beck, 2012).

The following research questions and hypotheses were utilized for this study:

**RQ1:** What is the overall relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses in the acute care setting?

*H1o:* There is no relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses.

*H1a:* The relationship of hospital ethical climate and perceptions of conscience will be positively related to stress of conscience among registered nurses.

**RQ2:** What is the relationship between perceptions of conscience and stress of conscience among registered nurses?

*H2o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H2a:* There is a positive, significant relationship between perceptions of conscience and stress of conscience among registered nurses.

**RQ3:** What is the relationship between perceptions of conscience and hospital ethical climate among registered nurses?

*H3o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H3a:* There is a positive, significant relationship between perceptions of climate and hospital ethical climate among registered nurses.

**RQ4:** What is the relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse?

*H4o:* There is no significant relationship between hospital ethical climate and stress of conscience among registered nurses controlling for age, gender, specialization and number of years working as a nurse.

*H4a:* There is a positive, significant relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse.

**RQ5:** How do demographic factors and job characteristics influence stress of conscience among registered nurses?

*H5o:* There is no influence of demographic factors and job characteristics on stress of conscience among registered nurses.

*H5a:* There is an influence of demographic factors and job characteristics on stress of conscience among registered nurses.

**RQ6:** How does perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographic and job characteristics?

*H6o:* There is no difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

*H6a:* There is a difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

This chapter represents the findings from the analysis of data generated from the above research questions. The chapter is divided into four sections. The first section provides a description of the sample. The next section presents the statistical analyses from the measurements and diagnostics results. The third section provides the statement of results pursuant to each of the hypotheses. The final section is a summary of the chapter. An in-depth discussion of the results and implications of this study will be addressed in Chapter 5.



### **Description of the Sample**

For the pre-analysis data treatment, initially 240 responses to the online survey were received. The data were screened for missing responses and accuracy. Forty-seven participants were removed for not answering key portions of the survey questionnaire with some only completing the demographics questions. All the remaining participants had scores within the theoretical range of possible values for hospital ethical climate, perception of conscience, and stress of conscience. The final sample consisted of 193 nurses for the objective statistical analyses and this number well exceeded the minimum sample size needed.

### **Frequencies and Percentages of Demographics**

Descriptive analysis was used to examine the characteristics of the sample. The subjects' demographic data showed the majority of the sample was female ( $n = 176$ , 91.2%). Ages of the nurse participants were fairly even in distribution with most nurses aged 21-29 ( $n = 60$ , 31.1%) and 30-39 ( $n = 61$ , 31.6%). The majority of nurses were of White ethnicity ( $n = 167$ , 86.5%). Most of the nurses involved had obtained a BSN ( $n = 94$ , 48.7%). For religious preference, most of the nurses involved were religiously affiliated with the Protestant faith ( $n = 74$ , 38.3%). The majority of the nurse participants worked full-time ( $n = 160$ , 82.9%) and most worked during the day shift ( $n = 131$ , 67.9%). The bed size at respective hospitals was approximately evenly distributed – 1-99 beds ( $n = 80$ , 41.5%), 100-300 beds ( $n = 57$ , 29.5%), and over 300 beds ( $n = 53$ , 27.5%). For type of nurse specialization, most of the nurses indicated that they worked in the medical-surgical clinical department ( $n = 58$ , 30.1%). The frequencies and percentages of the demographic characteristics are presented in Table 1.

Table 1

## Frequencies and Percentages of Demographic Characteristics

| Demographic                       | <i>n</i> | %    |
|-----------------------------------|----------|------|
| Gender                            |          |      |
| Male                              | 17       | 8.8  |
| Female                            | 176      | 91.2 |
| Age                               |          |      |
| 21-29                             | 60       | 31.1 |
| 30-39                             | 61       | 31.6 |
| 40-49                             | 36       | 18.7 |
| 50-59                             | 28       | 14.5 |
| 60 or older                       | 8        | 4.1  |
| Ethnicity                         |          |      |
| White                             | 167      | 86.5 |
| Black                             | 22       | 11.4 |
| American Indian or Alaskan Native | 1        | 0.5  |
| From Multiple Races               | 2        | 1.0  |
| Other                             | 1        | 0.5  |
| Education                         |          |      |
| Diploma in nursing                | 6        | 3.1  |
| ASN or AND                        | 58       | 30.1 |
| BSN                               | 94       | 48.7 |
| Bachelor's Degree (Other field)   | 16       | 8.3  |
| Master's Degree                   | 17       | 8.8  |
| Doctorate of Nursing Practice     | 2        | 1.0  |
| Religious Preference              |          |      |
| Catholic                          | 36       | 18.7 |
| Protestant                        | 74       | 38.3 |
| Spiritual, Not Religious          | 20       | 10.4 |

| Demographic                    | <i>n</i> | %    |
|--------------------------------|----------|------|
| Mormon                         | 2        | 1.0  |
| Jewish                         | 1        | 1.0  |
| Other                          | 51       | 26.4 |
| None                           | 9        | 4.7  |
| Work Hours                     |          |      |
| Full-time                      | 160      | 82.9 |
| Part-time                      | 10       | 5.2  |
| PRN                            | 21       | 10.9 |
| No response                    | 2        | 1.0  |
| Work Shift                     |          |      |
| Days (7-3 or 7AM-7PM)          | 131      | 67.9 |
| Evenings (3-11 PM)             | 2        | 1.0  |
| Nights (11-7 AM or 7PM-7AM)    | 60       | 31.1 |
| Bed Size at Hospital Facility  |          |      |
| 1-99 beds                      | 80       | 41.5 |
| 100-300 beds                   | 57       | 29.5 |
| Over 300 beds                  | 53       | 27.5 |
| No response                    | 3        | 2    |
| Clinical Unit                  |          |      |
| Medical-Surgical               | 58       | 30.1 |
| Emergency                      | 17       | 8.8  |
| Critical care                  | 41       | 21.2 |
| L&D/Postpartum/Newborn Nursery | 17       | 8.8  |
| Pediatrics                     | 7        | 3.6  |
| Peri-operative/OR              | 9        | 4.7  |
| Other                          | 44       | 22.8 |

*Note.* Due to rounding error, not all percentages may sum to 100.

## **Measurements and Diagnostic Results**

The survey consisted of three instruments: the Hospital Ethical Climate Scale (HECS), the Perceptions of Conscience Questionnaire (PCQ), and the Stress of Conscience Questionnaire (SCQ). Each participant was asked to respond to the questions posed on all of the instruments. Missing data were not used in any of the calculations. The questions on the demographic survey obtained a nominal level of measurement through force choice responses. The questions were not grouped but analyzed independently; however, years of nurse experience, specialization type and present hospital experience were examined for a correlation to the dependent variable.

### **Hospital Ethical Climate Scale**

The HECS instrument had five subscales which each included four to six questions regarding peers, hospital, managers and physicians and patients. Participants were asked to indicate the most appropriate response on a five-point Likert scale which ranged between 1 = almost never true, 2 = seldom true, 3 = sometimes true, 4 = often true, or 5 = almost always true. The total scores were additive and the higher scores indicated a positive, more favorable environment (Han, 2014). Scale validity and goodness of fit for this model was confirmed by Olson (1995). For this study, the HECS scores ranged from 1.69 to 4.96, with  $M = 3.65$  and  $SD = 0.69$  (see Table 2). The individual mean for the lowest items were for “Physicians ask nurses about their opinions about treatment decisions” ( $M = 2.80$ ,  $SD = 1.05$ ) and “Conflict is openly dealt with here and not avoided” ( $M = 2.98$ ,  $SD = 1.09$ ). The individual mean for the highest items were “My peers listen to my concerns about patient care” ( $M = 4.13$ ,  $SD = 0.79$ ) and “My peers help me with difficult patient care issues/problems” ( $M = 4.18$ ,  $SD = 0.87$ ). Overall,

the peer items reflected the highest means while items about nurse-physician relationships and hospital scored the lowest.

### **Perceptions of Conscience Questionnaire**

The PCQ utilized 16 statements which assessed participants' responses regarding their views on the important of conscience (its significance, origin and function). Six factors were measured on a 6-point Likert scale: conscience described as authority, a warning signal, demanding sensitivity, an asset, a burden, or depending on culture. Participants were asked to indicate their personal viewpoints ranging from 'No, totally disagree' (1) to 'Yes, entirely agree' (6). Items reflecting higher scores demonstrate increased importance to the participants (Dahlqvist et al., 2007). For the present study, perception of conscience scores ranged from 2.81 to 5.81, with  $M = 4.25$  and  $SD = 0.59$  (see Table 2). The individual mean for the highest value items involved conscience as a warning signal such as "Our conscience warns us against hurting ourselves" ( $M = 5.11$ ,  $SD = 0.91$ ) and "Our conscience warns us against hurting others" ( $M = 5.23$ ,  $SD = 0.88$ ). For the factor, conscience as an authority, item scores were also higher such as "God speaks to us through our conscience" ( $M = 4.79$ ,  $SD = 1.31$ ) and "When I follow my conscience I develop as a human being" ( $M = 4.88$ ,  $SD = 1.00$ ). The individual mean for the conscience as a burden category had the lowest scores and included items "I have to deaden my conscience in order to keep working in health care" ( $M = 2.62$ ,  $SD = 1.27$ ) and "My conscience is far too strict" ( $M = 2.54$ ,  $SD = 1.23$ ).

### **Stress of Conscience Questionnaire**

The SCQ was used to measure stress related to specific healthcare situations that could contribute to a troubled conscience among nurses. Nine items were represented and

each consisted of a part A and part B question. Part A posed an ethically difficult situation and participants were asked to indicate the frequency for which they encountered that situation. A six-point Likert scale was utilized and the responses ranged between ‘Never’ (0), ‘Less than once/6 months’ (1), ‘More than once/6 months’ (2), ‘Every month’ (3), ‘Every week’ (4), and ‘Every day’ (5). For the part B section of each item, participants were asked to indicate the perceived degree to which the situation caused a troubled conscience and response options ranged between ‘No, not at all’ (0) to ‘Yes, it gives me a very troubled conscience’ (5). Each item was carefully analyzed and the part A score was multiplied by the part B score for each item which created an index of the total stress of conscience. The indexes were added to obtain the overall scale score for total stress of conscience (Juthberg et al., 2010). The indexes reflecting a higher score indicates a stress of conscience (Dahlqvist et al., 2007; Ahlin et al., 2007).

Stress of conscience composite scores for this study ranged from 3.00 to 164.00, with  $M = 63.38$  and  $SD = 32.26$  (see Table 2). Data analysis indicated that the most frequent stress-inducing situation was, ‘How often do you lack time to provide the care the patient needs?’ ( $M = 4.33$ ,  $SD = 1.36$ ), and the least frequent situation was, “Do you ever find yourself avoiding patients or family members who need your help?” ( $M = 1.99$ ,  $SD = 1.23$ ). For the descriptive stress of conscience intensity subscale, the data analysis findings revealed the most stressful situations for a troubled conscience were items, “How often do you lack time to provide the care the patient needs?” ( $M = 3.46$ ,  $SD = 0.77$ ) and “Is your work in health care ever so demanding that you don’t have the energy to devote to your personal life as you would like?” ( $M = 3.42$ ,  $SD = 0.90$ ). The least

stressful situation related to troubled conscience was, “Are you ever forced to provide care that feels wrong?” ( $M = 2.47$ ,  $SD = 1.44$ ).

### **Descriptive Statistics of Continuous Variables**

Participants’ experience as a nurse ranged from 1.00 to 44.00 years, with the mean ( $M$ ) = 9.74 and  $SD = 10.62$ . The participants’ experience working at their current hospitals ranged from 1.00 to 31.00 years, with  $M = 5.79$  and  $SD = 5.99$ . The descriptive statistics of the continuous variables are presented in Table 2.

Table 2

Descriptive Statistics of Continuous Variables

| Continuous Variables                | <i>Min.</i> | <i>Max.</i> | <i>M</i> | <i>SD</i> |
|-------------------------------------|-------------|-------------|----------|-----------|
| Nurse experience (years)            | 1.00        | 44.00       | 9.74     | 10.62     |
| Present hospital experience (years) | 1.00        | 31.00       | 5.79     | 5.99      |
| Hospital ethical climate            | 1.69        | 4.96        | 3.65     | 0.69      |
| Perception of conscience            | 2.81        | 5.81        | 4.25     | 0.59      |
| Stress of conscience                | 3.00        | 164.00      | 63.38    | 32.26     |

### **Reliability**

Cronbach's alpha tests of reliability and internal consistency were conducted on the three scales. The Cronbach's alpha calculates the mean correlation between each pair of survey items and the number of items comprising the scale (Brace, Kemp, & Snelgar, 2012). A low alpha suggests there are errors in the selection of items to be included in the measure (Tappen, 2016). The alpha values were interpreted using the guidelines

suggested by George and Mallery (2016) where  $\alpha > .9$  excellent,  $> .8$  good,  $> .7$  acceptable,  $> .6$  questionable,  $> .5$  poor, and  $\leq .5$  unacceptable. All the scales met the acceptable threshold for internal consistency. The Cronbach's alpha reliability statistics are presented in Table 3.

Table 3

Cronbach's Alpha Reliability Statistics for Scales

| Scale                                   | No. of Items | $\alpha$ |
|---|--------------|----------|
| Hospital ethical climate                | 26           | .96      |
| Perception of conscience                | 16           | .79      |
| Stress of conscience (individual items) | 9            | .83      |
| Stress of conscience (multiplied items) | 9            | .84      |

### Statement of the Results

For the research questions in this study, the variables included hospital ethical climate (independent), perceptions of conscience (independent) and stress of conscience (dependent). An inspection of the correlation value of all data was conducted to identify significant relationships between the independent and dependent variables. After the correlation coefficients were calculated with Pearson's test, descriptive statistics were assessed for each hypothesis in the SPSS software program. A multiple regression analysis was then utilized to predict the value of multiple independent variables on one



dependent variable. Through the use of this analysis, the overall fit of the predictor variables could be determined to explain any variances as needed (Polit & Beck, 2012).

### **Research Question 1**

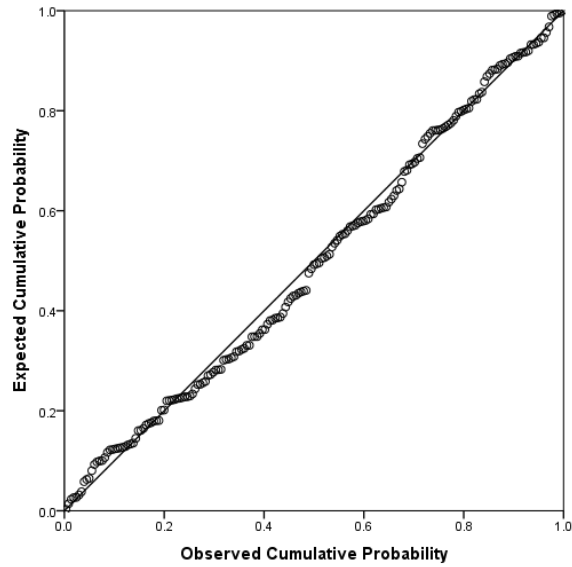
**RQ1:** What is the overall relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses in the acute care setting?

*H1o:* There is no relationship of hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses.

*H1a:* The relationship of hospital ethical climate and perceptions of conscience will be positively related to stress of conscience among registered nurses.

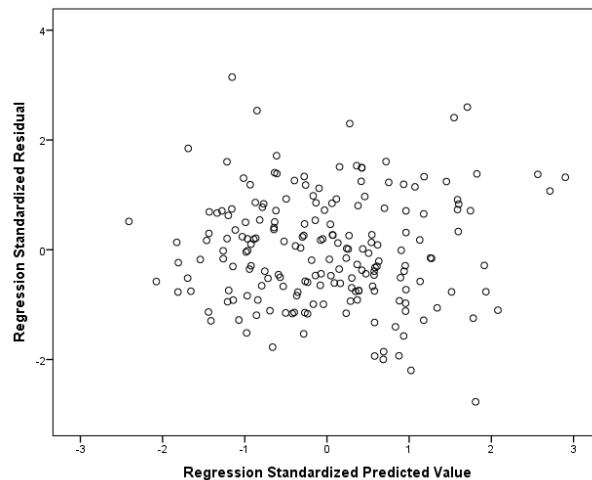
To address research question one, a multiple linear regression was conducted to examine the predictive relationship between hospital ethical climate and perceptions of conscience on stress of conscience. A multiple linear regression is an appropriate statistical analysis when assessing the strength of a group of predictors on a continuous criterion variable (Tabachnick & Fidell, 2013). The predictor variables corresponded to hospital ethical climate and perceptions of conscience. The continuous criterion variable corresponded to stress of conscience. Prior to analysis, the assumptions of a multiple linear regression were assessed.

The normality assumption was necessary to review as the sample size for this study was less than 200 (Statistics Solutions, 2013). A P-P scatterplot was examined to test the normality assumption (see Figure 1). This plots the observed values against the expected values, and an approximately straight line suggests that the distribution is normally distributed (Pallant, 2013). The data closely followed the normality trend line, suggesting that the assumption was met (Howell, 2013).



*Figure 1.* Normal P-P Scatterplot for Hospital Ethical Climate, Perceptions of Conscience, and Stress of Conscience

A residuals scatterplot was examined to assess the homoscedasticity assumption (see Figure 2). Homoscedasticity checks that variance in scores are approximately equal for all values of the dependent variable (Pallant, 2013). The data resembled a rectangular distribution and there was not a common pattern in the data; thus, the assumption for homoscedasticity was met (Stevens, 2009).



*Figure 2.* Residuals Scatterplot for Hospital Ethical Climate, Perceptions of Conscience, and Stress of Conscience

The absence of multicollinearity assumption checks that the predictor variables are not too closely correlated to one another. To test the assumption, Variance Inflation Factors (VIFs) were utilized. The assumption was met because the VIF values were less than 10 (Stevens, 2009).

**Results of multiple linear regression.** The results of the multiple linear regression were significant,  $F(2, 190) = 33.66, p < .001, R^2 = .262$ , initially suggesting that hospital ethical climate and perception of conscience significantly predicted stress of conscience. The coefficient of determination,  $R^2$ , suggested that approximately 26.2% of the variance in stress of conscience could be explained by hospital ethical climate and perception of conscience. The significant predictor variables were further examined.

Hospital ethical climate ( $t = -8.20, p < .001$ ) was a significant predictor in the model. For every one-unit increase in hospital ethical climate, stress of conscience scores decreased by 24.63 units. However, perception of conscience ( $t = 1.79, p = .074$ ), when

examined, was not a significant predictor in the model. The null hypothesis ( $H_0$ ) for research question one was partially rejected. Table 4 presents the results of the multiple linear regression.

Table 4

Linear Regression with Hospital Ethical Climate and Perception of Conscience Predicting Stress of Conscience

| Source                   | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|--------------------------|----------|-----------|---------|----------|----------|
| Hospital ethical climate | -24.63   | 3.01      | -.53    | -8.20    | <.001    |
| Perception of conscience | 6.30     | 3.51      | .12     | 1.79     | .074     |

\*Note: Overall model fit:  $F(2, 190) = 33.66, p < .001, R^2 = .262$

## Research Question 2

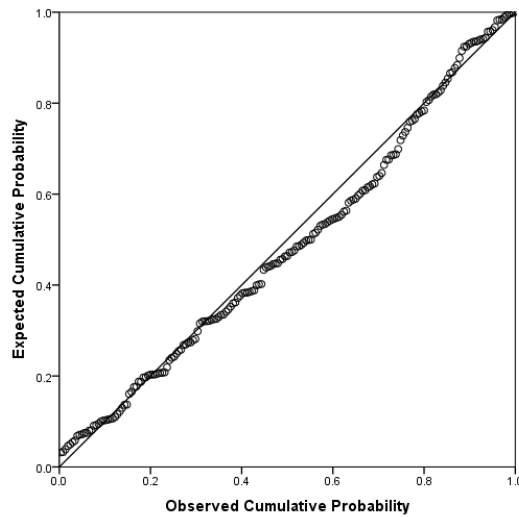
**RQ2:** What is the relationship between perceptions of conscience and stress of conscience among registered nurses?

*H2o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H2a:* There is a positive, significant relationship between perceptions of conscience and stress of conscience among registered nurses.

To address research question two, a linear regression was conducted to more closely examine the predictive relationship between perceptions of conscience and stress of conscience. The predictor variable corresponded to perceptions of conscience. The continuous criterion variable corresponded to stress of conscience. Prior to analysis, the assumptions of a linear regression were assessed. A P-P scatterplot was examined to test

the normality assumption (see Figure 5) and the normality trend line suggested that the assumption was met (Howell, 2013).



*Figure 3.* Normal P-P Scatterplot Perceptions of Conscience and Stress of Conscience

A residuals scatterplot was examined to assess the homoscedasticity assumption (see Figure 6) which checks for equal variance of both variables (Grove et al., 2013). The data resembled a rectangular distribution and there was not a common pattern in the data; thus, the assumption for homoscedasticity was met (Stevens, 2009). The absence of multicollinearity assumption was assessed to determine that the predictor variables are not too closely correlated to one another. Variance inflation factors (VIFs) revealed the assumption was met because the VIF values were less than 10 (Stevens, 2009).

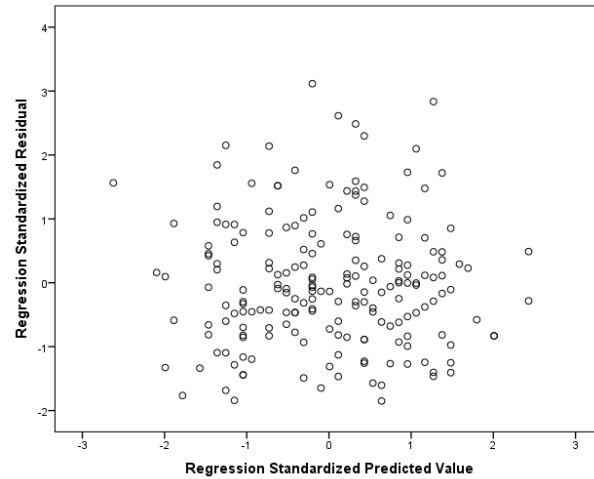


Figure 4. Residuals Scatterplot for Perceptions of Conscience and Stress of Conscience

**Results of linear regression.** The results of the linear regression were not significant,  $F(1, 191) = 0.10, p = .751, R^2 = .001$ , suggesting that perception of conscience alone does not have a predictive relationship on stress of conscience. The coefficient of determination,  $R^2$ , suggested that less than 1% of the variance in stress of conscience could be explained by the predictor, perceptions of conscience. Perception of conscience was not a significant predictor in the model. Therefore, the null hypothesis for research question three ( $H_{03}$ ) was not rejected. Table 5 presents the results of the linear regression.

Table 5

Linear Regression with Perception of Conscience Predicting Stress of Conscience

| Source                   | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|--------------------------|----------|-----------|---------|----------|----------|
| Perception of conscience | -1.25    | 3.93      | -.02    | -0.32    | .751     |

\*Note: Overall model fit:  $F(1, 191) = 0.10, p = .751, R^2 = .001$

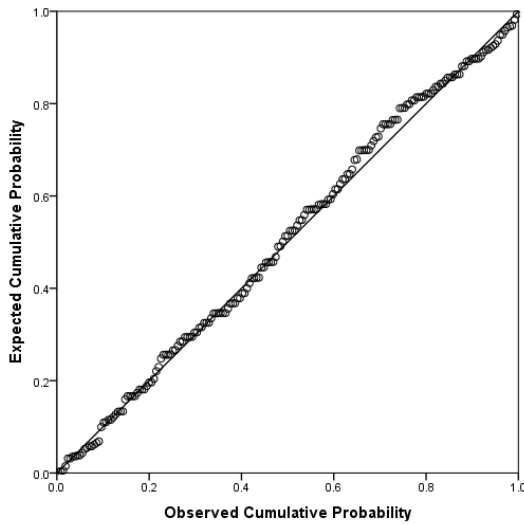
### **Research Question 3**

**RQ3:** What is the relationship between perceptions of conscience and hospital ethical climate among registered nurses?

*H3o:* There is no relationship between perceptions of conscience and stress of conscience among registered nurses.

*H3a:* There is a positive, significant relationship between perceptions of climate and hospital ethical climate among registered nurses.

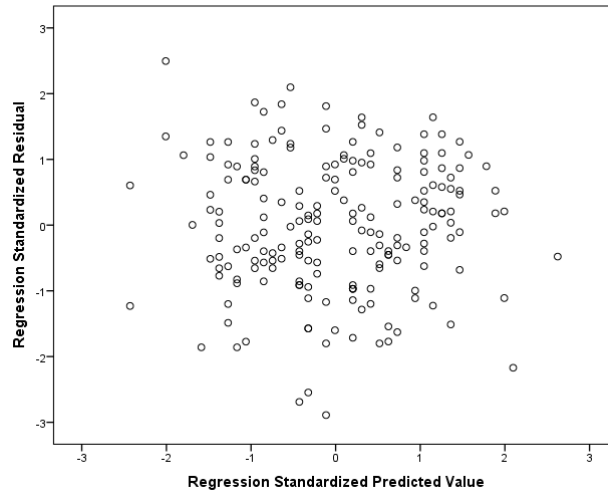
To address research question three, a linear regression was conducted to examine the predictive relationship between perception of conscience and hospital ethical climate. The predictor variable corresponded to perceptions of conscience. The continuous criterion variable corresponded to hospital ethical climate. Prior to analysis, the assumptions of a linear regression were assessed. A P-P scatterplot was examined to test the normality assumption (see Figure 3) and the normality trend line suggested that the assumption was met (Howell, 2013).



*Figure 5.* Normal P-P Scatterplot for Perceptions of Conscience and Hospital Ethical Climate

A residuals scatterplot was examined for this research question to assess the homoscedasticity assumption (see Figure 4). Data that are homoscedastic are evenly dispersed above and below the regression line, which indicates a linear relationship on the scatterplot (Grove et al., 2013). The data resembled a rectangular distribution and there was not a common pattern in the data; thus, the assumption for homoscedasticity was met (Stevens, 2009).





*Figure 6.* Residuals Scatterplot for Perception of Conscience and Hospital Ethical Climate

**Results of linear regression.** The results of the multiple linear regression were significant,  $F(1, 191) = 14.10, p < .001, R^2 = .069$ , suggesting that perception of conscience had a significant predictive relationship on hospital ethical climate. The coefficient of determination,  $R^2$ , suggested that approximately 6.9% of the variance in hospital ethical climate could be explained by the predictor, perception of conscience. Perception of conscience ( $t = 3.76, p < .001$ ) was a significant predictor in the model. For every one-unit increase in perception of conscience, hospital ethical climate scores increased by 0.31 units. The null hypothesis ( $H_03$ ) for research question three was rejected. Table 6 presents the results of the multiple linear regression.

Table 6

Linear Regression with Perception of Conscience Predicting Hospital Ethical Climate

| Source                   | <i>B</i> | <i>SE</i> | B   | <i>t</i> | <i>p</i> |
|--------------------------|----------|-----------|-----|----------|----------|
| Perception of conscience | 0.31     | 0.08      | .26 | 3.76     | <.001    |

\*Note: Overall model fit:  $F(1, 191) = 14.10, p < .001, R^2 = .069$

#### Research Question 4

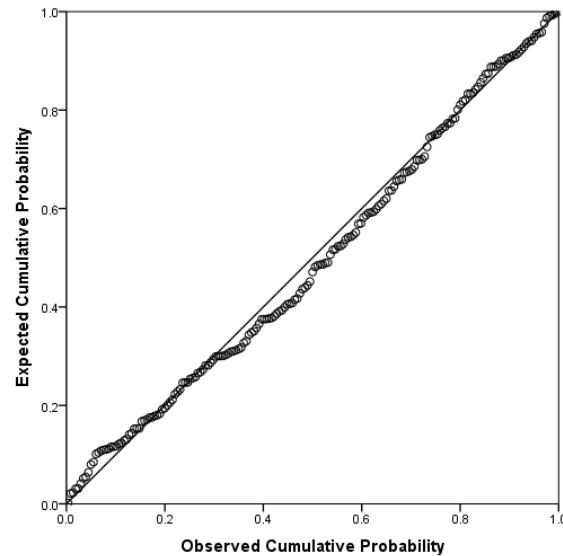
**RQ4:** What is the relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse?

*H4o:* There is no significant relationship between hospital ethical climate and stress of conscience among registered nurses controlling for age, gender, specialization and number of years working as a nurse.

*H4a:* There is a positive, significant relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse.

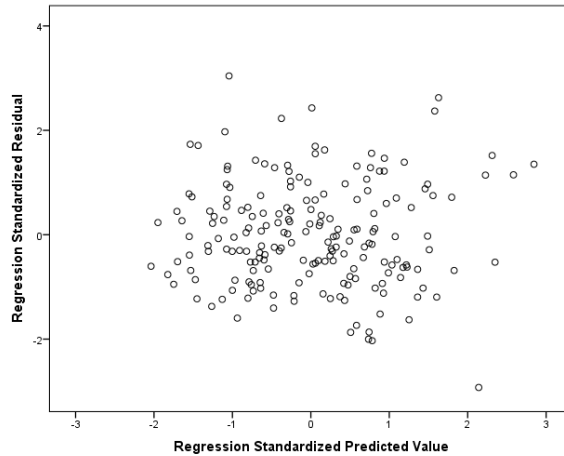
To address research question four, a hierarchical linear regression was conducted to examine the predictive relationship between hospital ethical climate and stress of conscience. A hierarchical linear regression is an appropriate statistical analysis when assessing the predictive relationship between a predictor variable on a continuous criterion variable, while controlling for additional variables (Tabachnick & Fidell, 2013). The predictor variable corresponded to hospital ethical climate and the continuous criterion variable corresponded to stress of conscience. The control variables

corresponded to age, gender, and number of years working as a nurse. Prior to analysis, the assumptions of a linear regression were assessed. A P-P scatterplot was examined to test the normality assumption (see Figure 7) and the normality trend line suggested that the assumption was met (Howell, 2013).



*Figure 7.* Normal P-P Scatterplot for Hospital Ethical Climate and Stress of Conscience, Controlling for Demographic Factors

A residuals scatterplot was examined to assess the homoscedasticity assumption (see Figure 8). The data resembled a rectangular distribution and there was not a common pattern in the data; thus, the assumption for homoscedasticity was met (Stevens, 2009). The absence of multicollinearity assumption was assessed to determine that the predictor variables are not too closely correlated to one another. Variance inflation factors (VIFs) revealed the assumption was met because the VIF values were less than 10 (Stevens, 2009).



*Figure 8.* Residuals Scatterplot for Hospital Ethical Climate and Stress of Conscience, Controlling for Demographic Factors

**Results of hierarchical linear regression.** Results of Step 1 of the hierarchical linear regression indicated that gender, age, and work experience do not significantly predict stress of conscience,  $F(4, 188) = 0.78, p = .539, R^2 = .016$ . The  $R^2$ —coefficient of determination— suggested that approximately 1.6% of the variance in stress of conscience could be explained by the demographic variables. Table 7 presents results for Step 1 of the hierarchical linear regression.

Table 7

Results for Hierarchical Linear Regression with Step 1 (Demographics Predicting Stress of Conscience)

| Source                           | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|----------------------------------|----------|-----------|---------|----------|----------|
| Gender (reference: male)         | 2.72     | 8.26      | .02     | 0.33     | .742     |
| Age                              | -1.93    | 3.03      | -.07    | -0.64    | .525     |
| Years of experience              | 0.08     | 0.34      | .03     | 0.24     | .810     |
| Clinical unit (reference: other) | 8.41     | 5.25      | .12     | 1.60     | .111     |

Note. Step 1:  $F(4, 188) = 0.78, p = .539, R^2 = 0.016$ .

Results of Step 2 of the hierarchical linear regression indicated that the gender, age, years of experience, and hospital ethical climate do significantly predict stress of conscience,  $F(5, 187) = 12.98, p < .001, R^2 = .258$ . The coefficient of determination,  $R^2$ , suggested that approximately 25.8% of the variance in stress of conscience could be explained by the demographics and hospital ethical climate. An additional 25% of variability in stress of conscience can be explained by the inclusion of hospital ethical climate in the model beyond what is accounted for by demographic characteristics alone.

Upon further examination of the predictor variables in Step 2, hospital ethical climate ( $t = -7.80, p < .001$ ) was found to be a significant predictor in the model. With every one-unit increase in hospital ethical climate, participants' stress of conscience scores decreased by 23.16 units. The null hypothesis for research question four (H<sub>04</sub>) was rejected. Table 8 presents results for Step 2 of the hierarchical linear regression.

Table 8

Results for Hierarchical Linear Regression with Step 2 (Demographics and Hospital Ethical Climate Predicting Stress of Conscience)

| Source                           | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|----------------------------------|----------|-----------|---------|----------|----------|
| Gender (reference: male)         | -2.58    | 7.23      | -.02    | -0.36    | .722     |
| Age                              | -2.02    | 2.64      | -.07    | -0.76    | .446     |
| Years of experience              | 0.24     | 0.29      | .08     | 0.81     | .417     |
| Clinical unit (reference: other) | 6.05     | 4.58      | .09     | 1.32     | .118     |
| Hospital ethical climate         | -23.16   | 2.97      | -.50    | -7.80    | <.001    |

Note. Step 2:  $F(5, 187) = 12.98, p < .001, R^2 = 0.258$

### Research Question 5

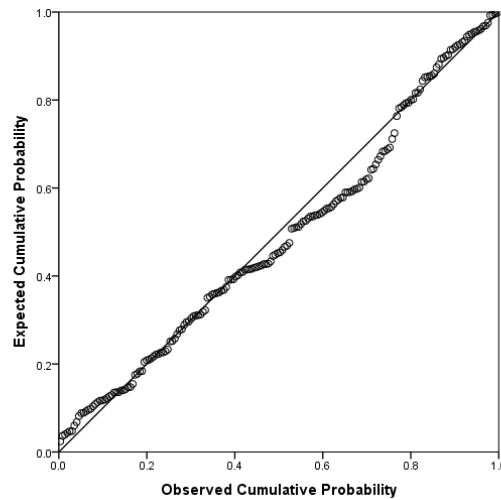
**RQ5:** How do demographic factors and job characteristics influence stress of conscience among registered nurses?

*H5o:* There is no influence of demographic factors and job characteristics on stress of conscience among registered nurses.

*H5a:* There is an influence of demographic factors and job characteristics on stress of conscience among registered nurses.

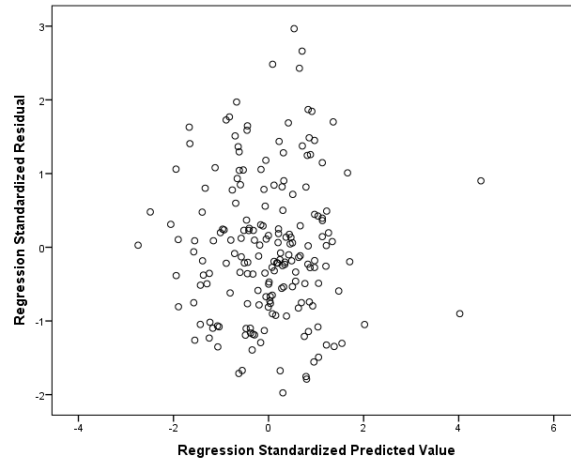
To address research question five, a multiple linear regression was conducted to examine the predictive relationship between demographic factors and job characteristics on stress of conscience. The predictor variables corresponded to demographic factors and job characteristics. The continuous criterion variable corresponded to stress of conscience. The assumptions of a multiple linear regression were assessed prior to

analysis. A P-P scatterplot was examined to test the normality assumption (see Figure 9) and the normality trend line suggested that the assumption was met (Howell, 2013).



*Figure 9.* Normal P-P Scatterplot for Demographic Factors and Job Characteristics on Stress of Conscience

A residuals scatterplot was examined to assess the homoscedasticity assumption (see Figure 10). The data resembled a rectangular distribution and there was not a common pattern in the data; thus, the assumption for homoscedasticity was met (Stevens, 2009). The absence of multicollinearity assumption was assessed to determine that the predictor variables are not too closely correlated to one another. Variance inflation factors (VIFs) revealed the assumption was met because the VIF values were less than 10 (Stevens, 2009).



*Figure 10.* Residuals Scatterplot for Demographic Factors and Job Characteristics on Stress of Conscience

**Results of multiple linear regression.** The results of the multiple linear regression were not significant,  $F(13, 174) = 1.45$ ,  $p = .139$ ,  $R^2 = .098$ , suggesting that demographic factors and job characteristics did not significantly predict stress of conscience. The coefficient of determination,  $R^2$ , suggested that approximately 9.8% of the variance in stress of conscience could be explained by the demographic traits and job characteristics. Due to non-significance of the overall regression model, the individual predictors were not examined further. The null hypothesis ( $H_05$ ) for research question five cannot be rejected. Table 9 presents the results of the multiple linear regression.



Table 9

Linear Regression with Demographics and Job Characteristics Predicting Stress of  
Conscience

| Source                           | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|----------------------------------|----------|-----------|---------|----------|----------|
| Gender (reference: male)         | -0.86    | 8.79      | -.01    | -0.09    | .922     |
| Age                              | -1.88    | 3.22      | -.07    | -0.59    | .560     |
| Education level                  | 1.37     | 2.65      | .04     | 0.52     | .607     |
| Ethnicity (reference: White)     | -0.29    | 6.92      | -.00    | -0.04    | .967     |
| Nurse experience                 | 0.26     | 0.37      | .08     | 0.70     | .488     |
| Present hospital experience      | -0.69    | 0.50      | -.13    | -1.39    | .166     |
| Clinical unit (reference: other) | 7.05     | 5.41      | .10     | 1.30     | .195     |
| Hospital hours                   |          |           |         |          |          |
| Part-time vs Full-time           | -8.83    | 11.10     | -.06    | -0.80    | .428     |
| PRN vs Full-time                 | -5.45    | 8.20      | -.05    | -0.67    | .507     |
| Work schedule                    |          |           |         |          |          |
| Evenings vs Days                 | 50.66    | 23.70     | .16     | 2.14     | .034     |
| Nights vs Days                   | 6.32     | 5.51      | .09     | 1.15     | .253     |
| Hospital beds                    |          |           |         |          |          |
| 100-300 beds vs 1-99 beds        | -16.10   | 5.92      | -.23    | -2.72    | .007     |
| over 300 beds vs 1-99 beds       | -1.78    | 6.14      | -.03    | -.29     | .772     |

Note.  $F(13, 174) = 1.45, p = .139, R^2 = 0.098$ .

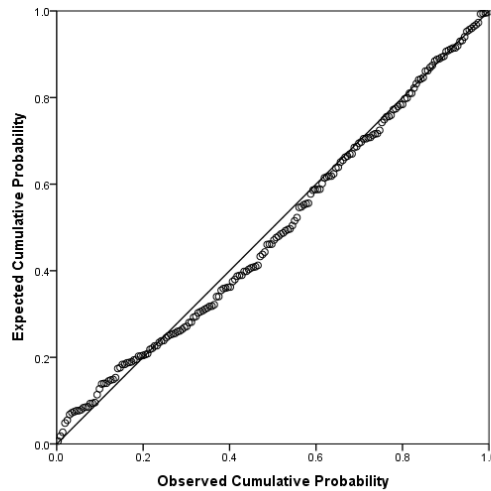
## Research Question 6

**RQ6:** How does perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographic and job characteristics?

*H6o:* There is no difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

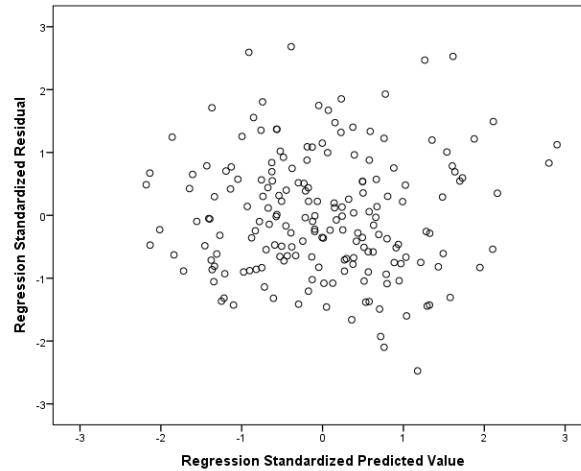
*H6a:* There is a difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

To address research question six, a hierarchical linear regression was conducted to examine the predictive relationship between perceptions of conscience and hospital ethical climate on stress of conscience, while controlling for demographic and job characteristics. The predictor variable corresponded to perceptions of conscience and hospital ethical climate. The continuous criterion variable corresponded to stress of conscience. The control variables corresponded to gender, age, education, ethnicity, nurse experience, present hospital experience, hospital hours, work schedule, and hospital beds. Prior to analysis, the assumptions of a linear regression were assessed. A P-P scatterplot was examined to test the normality assumption (see Figure 11) and the normality trend line suggested that the assumption was met (Howell, 2013).



*Figure 11.* Normal P-P Scatterplot for Demographic Characteristics, Job Duties, Perception on Conscience, and Hospital Ethical Climate Predicting Stress of Conscience

A residuals scatterplot was examined to assess the homoscedasticity assumption (see Figure 12). The data resembled a rectangular distribution and there was not a common pattern in the data; thus, the assumption for homoscedasticity was met (Stevens, 2009). The absence of multicollinearity assumption was assessed to determine that the predictor variables are not too closely correlated to one another. Variance inflation factors (VIFs) revealed the assumption was met because the VIF values were less than 10 (Stevens, 2009).



*Figure 12.* Residuals Scatterplot for Demographic Factors, Job Characteristics, Perceptions of Conscience, and Hospital Ethical Climate Predicting Stress of Conscience

**Results of hierarchical linear regression.** The results of the multiple linear regression were not significant,  $F(13, 174) = 1.45, p = .139, R^2 = .098$ , suggesting that demographic factors and job characteristics did not significantly predict stress of conscience. The coefficient of determination,  $R^2$ , suggested that approximately 9.8% of the variance in stress of conscience could be explained by the demographic traits and job characteristics. Due to non-significance of the overall regression model, the individual predictors were not examined further. Table 10 presents the results of the multiple linear regression.

Table 10

Linear Regression with Demographics and Job Characteristics Predicting Stress of  
Conscience (Step 1)

| Source                           | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|----------------------------------|----------|-----------|---------|----------|----------|
| Gender (reference: male)         | -0.86    | 8.79      | -.01    | -0.10    | .922     |
| Age                              | -1.88    | 3.22      | -.07    | -0.59    | .560     |
| Education level                  | 1.37     | 2.65      | .04     | 0.52     | .607     |
| Ethnicity (reference: White)     | -0.29    | 6.92      | -.01    | -0.04    | .967     |
| Nurse experience                 | 0.26     | 0.37      | .08     | 0.70     | .488     |
| Present hospital experience      | -0.69    | 0.50      | -.13    | -1.39    | .166     |
| Clinical unit (reference: other) | 7.05     | 5.41      | .10     | 1.30     | .195     |
| Hospital hours                   |          |           |         |          |          |
| Part-time vs Full-time           | -8.83    | 11.10     | -.06    | -0.80    | .428     |
| PRN vs Full-time                 | -5.45    | 8.21      | -.05    | -0.67    | .507     |
| Work schedule                    |          |           |         |          |          |
| Evenings vs Days                 | 50.66    | 23.69     | .16     | 2.14     | .034     |
| Nights vs Days                   | 6.32     | 5.52      | .09     | 1.15     | .253     |
| Hospital beds                    |          |           |         |          |          |
| 100-300 beds vs 1-99 beds        | -16.10   | 5.92      | -.23    | -2.72    | .007     |
| over 300 beds vs 1-99 beds       | -1.78    | 6.14      | -.03    | -0.29    | .772     |

Note.  $F(13, 174) = 1.45, p = .139, R^2 = 0.098$ .

Results of Step 2 of the hierarchical linear regression indicated that the demographics, job characteristics, perceptions of conscience, and hospital ethical climate do significantly predict stress of conscience,  $F(15, 172) = 5.24, p < .001, R^2 = .314$ . The coefficient of determination,  $R^2$ , suggested that approximately 31.4% of the variance in stress of conscience could be explained by the demographics, perceptions of conscience, and hospital ethical climate. An additional 21.6% of variability in stress of conscience can be explained by the inclusion of perceptions of conscience and hospital ethical climate in the model beyond what is accounted for by demographic factors and job characteristics alone.

Upon further examination of the predictor variables in Step 2, perceptions of conscience ( $t = 1.81, p = .072$ ) and hospital ethical climate ( $t = -7.32, p < .001$ ) were found to be significant predictors in the model. With every one-unit increase in perceptions of conscience, participants' stress of conscience scores increased by 6.85 units. With every one unit increase in hospital ethical climate, participants' stress of conscience scores decreased by 25.37 units. The null hypothesis for research question six ( $H_{06}$ ) was rejected. Table 11 presents results for Step 2 of the hierarchical linear regression.

Table 11

Linear Regression with Demographics, Job Characteristics, Perceptions of Conscience, and Hospital Ethical Climate Predicting Stress of Conscience (Step 2)

| Source                           | <i>B</i> | <i>SE</i> | $\beta$ | <i>t</i> | <i>p</i> |
|----------------------------------|----------|-----------|---------|----------|----------|
| Gender (reference: male)         | -2.99    | 7.73      | -.03    | -0.39    | .699     |
| Age                              | -1.77    | 2.84      | -.06    | -0.62    | .534     |
| Education level                  | -1.50    | 2.36      | -.05    | -0.64    | .526     |
| Ethnicity (reference: White)     | -5.78    | 6.12      | -.06    | -0.94    | .346     |
| Nurse experience                 | 0.29     | 0.33      | .09     | 0.88     | .381     |
| Present hospital experience      | -0.14    | 0.44      | -.03    | -0.32    | .746     |
| Clinical unit (reference: other) | 4.27     | 4.84      | .06     | 0.88     | .378     |
| Hospital hours                   |          |           |         |          |          |
| Part-time vs Full-time           | -17.18   | 9.81      | -.12    | -1.75    | .082     |
| PRN vs Full-time                 | -3.30    | 7.23      | -.03    | -0.46    | .648     |
| Work schedule                    |          |           |         |          |          |
| Evenings vs Days                 | 19.76    | 21.22     | .06     | 0.93     | .353     |
| Nights vs Days                   | 0.13     | 4.93      | .00     | 0.03     | .979     |
| Hospital beds                    |          |           |         |          |          |
| 100-300 beds vs 1-99 beds        | -6.76    | 5.35      | -.10    | -1.26    | .208     |
| over 300 beds vs 1-99 beds       | 7.03     | 5.53      | .10     | 1.27     | .205     |
| Perceptions of conscience        | 6.85     | 3.78      | .13     | 1.81     | .072     |
| Hospital ethical climate         | -25.37   | 3.46      | -.54    | -7.32    | <.001    |

Note.  $F(15, 172) = 5.24, p < .001, R^2 = 0.314$ .

## **Chapter Summary**

This chapter presented the findings of the data collection process using a homogenous subject population of 193 registered nurses in a U.S. southern state. Data were first screened for completion and accuracy. Descriptive statistics were conducted for the demographic traits and continuous variables. A reliability analysis was conducted on the scales by use of Cronbach's alpha statistics. Correlational and regression analysis were used to test each null hypothesis. The detailed analysis was then presented by research question and corresponding hypotheses.

Three pre-established instruments were used to collect data: the Hospital Ethical Climate Scale (Olson, 1995), Perceptions of Conscience Questionnaire (Glasberg et al., 2006) and the Stress of Conscience Questionnaire (Dahlqvist et al., 2006). All instruments had demonstrated previous records of established reliability and validity from previous studies. The perceived levels of hospital ethical climate, the perceptions of conscience and the level of stress of conscience according to frequency and intensity were measured and examined using descriptive statistical analysis. Additional information was also gained from analysis of the demographic information for the subjects related to two of the major variables of ethical climate and stress of conscience with some statistically significant results.

The data analysis related to six research questions for this study was presented. Results of the multiple regression for research question one examined the overall relationship of hospital ethical climate and perceptions of conscience together on stress of conscience. The results for this were mixed and indicated that hospital ethical climate was positively related to stress of conscience; however, perceptions of conscience was



not related to stress of conscience in the overall model. Therefore, the null hypothesis for research question one (H<sub>01</sub>) was partially rejected since a significant relationship was not demonstrated from the analysis. This was examined more closely in the second hypothesis, and a linear regression was conducted to determine the predictive relationship between perceptions of conscience and stress of conscience. However, findings indicated that perceptions of conscience was not a significant predictor for stress of conscience and as such, the null hypothesis for research question two (H<sub>02</sub>) was not rejected.

Linear regression was also utilized for research question three. For this research question, a perception of conscience was found to be a significant predictor of hospital ethical climate. Thus, the null hypothesis for research question three (H<sub>03</sub>) was rejected. Research question four sought to determine if a relationship existed between hospital ethical climate and stress of conscience in the acute care setting controlling for age, gender, specialization and number of years working as a nurse. Results of the hierarchical linear regression for this question indicated that hospital ethical climate was a significant predictor of stress of conscience, while controlling for demographic characteristics. Therefore, the null hypothesis for research question four (H<sub>04</sub>) was rejected. Research question five examined the influence of demographics and job characteristics on stress of conscience among nurses. Findings revealed that the null hypothesis for this question (H<sub>05</sub>) could not be rejected as the results of the linear regression indicated that demographics and job duties were not significant predictors of stress of conscience.

The hypothesis for research question six asked if a difference existed in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics.

Findings revealed that with a score increase in the nurses' perception of conscience (conscience as authority and a warning signal), the nurses' stress of conscience scores also increased. However, with each unit of increase in the nurses' perception of hospital ethical climate, which indicated a more positive perception of the work environment, the stress of conscience scores decreased. Results of the hierarchical linear regression for research question six indicated that perceptions of conscience and hospital ethical climate were significant predictors of stress of conscience, while controlling for demographic characteristics and job characteristics. Therefore, the null hypothesis for research question six ( $H_{06}$ ) was rejected.

These statistical findings from this study will be discussed in further detail in the next chapter in relation to the research questions and hypotheses. A review of the conclusions made from these results will be provided and a discussion on the implication of the findings for both the nursing profession and health care leadership will be given. Additionally, connections will be made back to the literature and theoretical framework selected for the research. Finally, the study limitations will be discussed and recommendations for future research will be provided.

## **CHAPTER 5. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS**

### **Introduction**

This quantitative study examined the relationship between hospital ethical climate and perceptions of conscience on stress of conscience among registered nurses working in the acute hospital setting in Louisiana. In addition, the study examined the predictor variables that most significantly impacted a troubled conscience in nurses, including whether years of professional experience, demographics and job characteristics had an impact on the relationship. If a positive, significant relationship was found and specific variables related to hospital ethical climate and perceptions of conscience could influence this relationship, then perhaps pursuing strategies which address a stress of conscience in registered nurses could be explored by healthcare administrators.

The purpose of this chapter is to discuss the data analysis findings and associated conclusions from this study. The implications for the nursing profession and healthcare leadership will be provided. Limitations of the study will also be addressed. Finally, the chapter concludes with a discussion of recommendations for further research.

### **Summary of the Results**

This research involved 193 registered nurses who work in hospitals across the state of Louisiana. The demographics of the sample were compared to those from previous studies to examine the overall representation. Female nurses represented 91% in this study which is similar to prior studies (Ericson-Lidman & Ahlin, 2015; Han, 2014; Hart, 2005; Hwang & Park, 2014; Numminen et al., 2015). For educational preparation, this study showed that 49% of the nurses held a bachelor of science in nursing (BSN) degree which is similar to the Han (2014) study. A difference found in the current study's

sample was related to the age of the nurse participants. In previous studies which investigated variables associated with perceptions of conscience and stress of conscience, the average age of participants ranged between 45 and 54 years (Ericson-Lidman & Ahlin, 2015; Glasberg et al., 2008; Hanna & Mona, 2014; Jensen & Liddell, 2009; Tuvevsson et al., 2012). This study showed that 63% of the nurses had ages which ranged between 21 and 39 years. However, this is similar to previous studies that examined variables associated with hospital ethical climate (Hwang & Park, 2014; Numminen et al., 2015; Silen et al., 2012).

Results from this study found 51% of the nurses reported less than 5 years of experience working in the nursing profession. The average for the entire sample was 9.9 years of experience which corresponds to previous studies (Hart, 2005; Hwang & Park, 2014; Silen et al., 2012). Additionally, the study participants primarily worked the day shift (68%) and were employed full time (83%), and this also is comparative to other studies (Ericson-Lidman & Ahlin, 2015; Hwang & Park, 2014). The nurses reported that they worked in a variety of acute care settings such as medical-surgical, emergency, critical care, obstetrics, pediatrics, peri-operative, and psychiatric units. The majority of nurses however, worked in the medical-surgical departments, which corresponds to other studies (Glasberg et al., 2008; Hanna & Mona, 2014; Hwang & Park, 2014).

Approximately 57% of the sample had a religious affiliation with either the Catholic or Protestant faiths while 10% of the nurses reported they were spiritual but not religious.

There were six research questions that sought to determine possible relationships between hospital ethical climate, perceptions of conscience and stress of conscience among registered nurses working in hospitals. A correlation analysis was completed

between individual variables and a standard linear and hierarchical regression analysis was also conducted to determine relationships between the independent and dependent variables. Overall, the findings revealed mixed results. Research question one sought to examine the model by determining the relationship of hospital ethical climate and perceptions of conscience on stress of conscience. Partial support was found for the first hypotheses which showed a positive, significant relationship between hospital ethical climate and stress of conscience. However, no significance was found between the relationship of perceptions of conscience and stress of conscience in the overall model. Using linear regression, this was examined further in research question two by determining whether perceptions of conscience had a predictive relationship on stress of conscience. The finding for research question two was rejected, which indicated that perceptions of conscience did not have a predictive relationship on stress of conscience among registered nurses. Additionally, the hypothesis for research question five revealed that demographic factors and job duties alone do not influence stress of conscience.

However, the null hypotheses were rejected for the other three hypotheses in this study. A positive, significant relationship between perceptions of conscience and hospital ethical climate was supported for research question three. For research question four, a significant relationship between hospital ethical climate and stress of conscience among registered nurses was found to exist while controlling for age, gender, specialization and numbers of years working in the profession. Support was also found for the hypothesis in research question six and showed that there is a difference in how perceptions of conscience and ethical climate influence stress of conscience above and beyond associated demographics and job characteristics. While demographics and job

characteristics alone did not influence stress of conscience in nurses, there was an influence on this variable in the overall model when perceptions of conscience and hospital ethical climate were added together. This appears to be related to the positive, significant relationship that perceptions of conscience had on hospital ethical climate. When examined in a hierarchal approach the relationship among the three variables was established which can be seen in the results model in Figure 13.

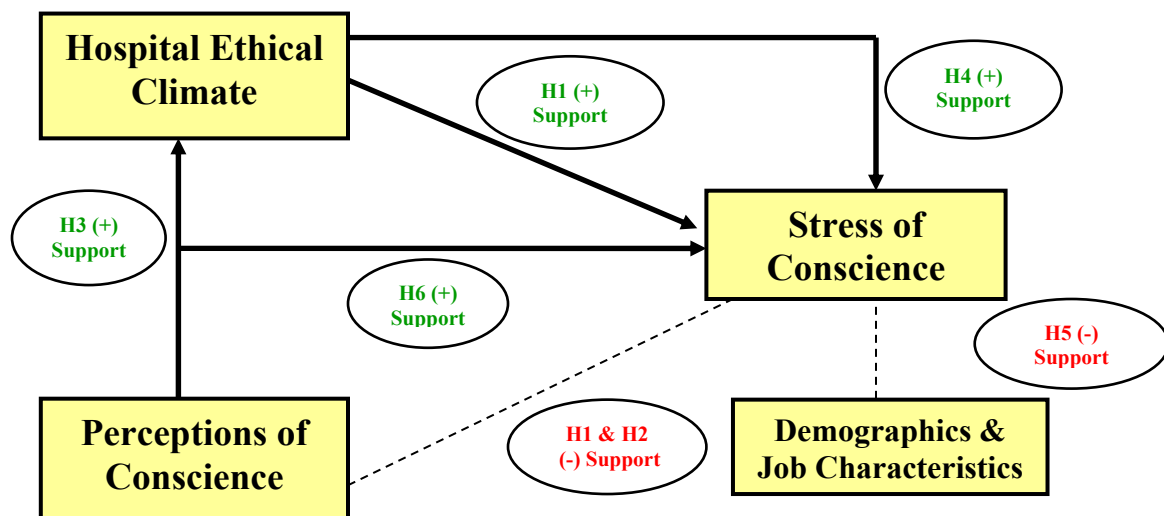


Figure 13. Depiction of Results Model

### Discussion of the Results

Moral distress among registered nurses continues to be a concern to nurse leaders and other healthcare administrators in the United States (Edmonson, 2010; MacKusick & Minick, 2010). Identifying factors that may influence the incidence and negative outcomes posed by this issue is an important step to identify possible interventions to mitigate this challenge in the nursing profession. After an extensive literature review describing the consequence of moral distress in nursing, such as emotional exhaustion, burnout, turnover and intent to leave, this study was conducted to provide additional

information regarding the potential antecedents which may lead to conflicts of moral agency in the nurse. Specifically, understanding issues associated with moral sensitivity in the workplace as described in the literature review revealed that a paucity of research existed in the United States about the role that conscience plays overall and how ethical climate and the nurse's perception of conscience may be related to factors in the work environment that lead to a troubled conscience (Jensen, 2009; Laabs, 2011).

In understanding stress of conscience, the perceptions of registered nurses who work in the acute care hospital setting and are specialized in a variety of nursing units and departments serve an important role in understanding the possible cause and identifying positive solutions. The altruistic nature of nursing suggests that nurses are beneficent and bring to the profession certain beliefs and values that contribute to the organizational climate. Determining the significance of perceptions of conscience on nursing practice as derived from the nurses' personal beliefs and values are important. These perceptions provide a lens into the ethical work environment from nurses who are directly responsible for providing safe, high-quality patient care on a daily basis. Moreover, additional insight is garnered by examining the perceived relationships that exist among interdisciplinary team members, especially among nursing peers and between nurses and physicians. The dynamic interactions which occur during ethical dilemmas where conflicting values surface may lead to irresolvable moral imperatives that contradict or compete with each other (Lutzen, Dahlqvist, Eriksson, & Norberg, 2006). Individual factors such as these were considered and investigated throughout this study to determine if there were significant relationships that could serve as predictors of stress of conscience in nurses.

The purpose of this predictive correlational study was to establish if there is a positive, significant relationship between hospital ethical climate and perceptions of conscience on stress of conscience as perceived by registered nurses in Louisiana. Also examined was the extent to which nurse demographics and job characteristics possibly influence stress of conscience in the work setting. Additionally, the relationship among the independent variables and dependent variables were analyzed. Descriptive statistics were used to examine the results of this study by providing a graphic of the sample population and to determine any differences among the participants. A comparative analysis revealed that the sample population for this study shared several similarities with previous studies as described in the literature review.

Data analysis for the first research question was directed to determine if any positive, significant relationships existed in the overall model by examining the relationship of perceptions of conscience and hospital ethical climate on stress of conscience among registered nurses. For the hypothesis to be accepted, a positive relationship would have to be supported by the data. The results of the correlational analysis and the multiple regression showed a statistical significance between hospital ethical climate and stress of conscience in nurses. The data revealed that for each increase in hospital ethical climate, the stress of conscience scores decreased. This indicated that the more nurse respondents viewed their ethical climate as positive and supportive, the lower the scores were for reporting a troubled conscience. This finding is supported in the literature. Ethical climate research (Hwang & Park, 2014; Joseph & Deshpande, 1997; Numminen et al., 2014) investigating risk factors such as job turnover, intent to leave the



profession and burnout were also shown to be decreased when nurses reported working in a caring climate.

Additionally, the results of the current study show that negative perceptions of the ethical climate were related to a higher stress of conscience indicating that in a work environment lacking support and collegiality, the more likely nurses experience a troubled conscience. Pursuant to the data analysis, team relationships within the work environment were found in items with the highest and lowest scores. The most positive views reported by the respondents were of their colleagues and their perceptions that safe patient care was provided in their nursing units. This finding suggests that the respondents strongly value their peer interactions and having nurses support each other so that patient care needs can be consistently and safely met. Relationships with nurse managers scored lower in the study and the item asking about whether the nurses trusted their managers reflected the lowest score for that subscale. Results from previous studies reveal similar findings which indicate that the role of the nurse manager is significant in promoting a positive work environment (Joseph & Deshpande, 1997; Numminen et al., 2014; Wallin, 2013) and that poor managerial social support is related to stress of conscience (Glasberg et al., 2008).

However, an interesting finding was in the hospital ethical climate questions having the lowest overall scores. These questions were associated with nurse-physician relationships and conflict. One of the lowest scoring items dealt with whether nurses and physicians respect each other's opinions even when they disagree about what is best for the patient. Another item was the question regarding whether physicians ask nurses about their opinions related to treatment decisions. Both of these items received low scores by

the nurse respondents. The findings indicate that a power gradient between physicians and nurses exists and that the actual interdisciplinary team approach for integrated decision making seems to be primarily controlled by the physician. As a result, necessary communication between the nurse and physician for patient care coordination will be limited with the possibility of pertinent information being delayed, overlooked or omitted. The benefit of quality patient care is then potentially compromised and poor team communication places patient safety at risk (Catalano, 2015).

Conflict issues appeared to be problematic for the nurse respondents as well. Two questions, “Conflict is openly dealt with here and not avoided” and “Nurses on this unit are able to openly disagree without fear of reprisal”, were among the lowest scores in this study. This correlated with higher stress of conscience scores. One possible explanation for this finding is that raising patient care concerns by questioning and through disagreement among team members on the nursing units or within certain nursing departments may not be valued. Thus, the discouragement of individual disagreement about a patient issue or team behaviors can be the usual manner of operation as reflected by the oppression of opinions. As noted by Olson (1998), these factors contribute to the overall ethical climate of the healthcare setting. In a negative work environment where individuality is diminished or oppressed, the nurse’s moral agency can be threatened (Lutzen et al., 2010). The inability to act on one’s values leads to internal conflict and situations that prohibit the nurse from expressing ethical or moral concerns and interceding on the patient’s behalf lead to moral distress and a stress of conscience. A culture of conformity may suppress the nurse’s ability to address feelings associated with a stress of conscience and moral distress. These findings are consistent with the literature

(Hamric & Blackhall, 2007; Hart, 2005; Hwang & Park, 2014; Juthberg et al., 2008; Pauly et al., 2009; Schluter et al., 2008; Tuveesson & Eklund, 2014; Tuveesson et al., 2012; Whitehead et al., 2015).

The significance of the relationship between perceptions of conscience and stress of conscience as part of the overall model was also investigated for the first hypothesis. However, when examined separately, the perceptions of conscience by nurses did not appear to be positively related to stress of conscience. As indicated by the analysis, the hypothesis for the first research question was only partially supported and the null hypothesis could not be rejected due to the initial findings related to the independent variable perceptions of conscience.

For research question two, perceptions of conscience was examined more closely and a predictive relationship between perceptions of conscience on stress of conscience was analyzed using linear regression. The results revealed that a predictive relationship did not exist between these two variables and the null hypothesis was not rejected. This suggests that conscience, when viewed internally as an authority or an asset, does not necessarily mean that these beliefs will directly lead to a troubled conscience in the nurse. In this study, these subscales received high scores overall by the respondents. The subscale for “conscience being perceived as a burden” had the lowest score, suggesting that most of the nurses did not report having to deaden their consciences to keep working in healthcare, nor did they perceive that their consciences were too strict. Glasberg et al. (2008) reported similar findings in their study and found that it was the qualities of conscience such as having to deaden one’s conscience and not being able to follow it that most predicted a stress of conscience.

To answer research question three, another correlational analysis was conducted to assess the relationship significance between the independent variables, perceptions of conscience and hospital ethical climate among registered nurses. Data analysis from the linear regression was significant indicating that perceptions of conscience among nurses had a predictive relationship on hospital ethical climate. The unit increases in perceptions of conscience indicated higher importance to the nurses. As each unit increased in the model, hospital ethical climate scores also increased suggesting a positive and more favorable environment for the nurses. The majority of respondents agreed that nurses should follow their consciences no matter what others think and that by following their consciences, they developed as human beings. A high item score was indicated for the statement, “God speaks to us through our conscience.” A majority of nurses in this study appeared to connect God as a conduit for speaking to them and this correlated with nurses’ perceiving that conscience was an asset. This may be explained by the large number of nurse respondents who indicated a religious preference for either the Catholic or Protestant faith in this study. This was contradictory to the Ahlin et al. (2012) research findings which showed, for their study, a large number of missing items to this question may have been related to the Swedish culture, which reportedly has the largest number of atheists and agnostics in the world (Zuckerman, 2007). The researchers suggested that in nations such as the United States, the relevancy of this question might have higher significance and a response by participants would be less difficult to render (Ahlin et al., 2012). The results from this study appear to support this suggestion.

Additionally, items for the subscale of conscience as a warning signal also scored high as a large majority of respondents agreed that one’s conscience warns against

hurting others as well as the self. These responses positively correlated with the hospital ethical climate items associated with the peers subscale. This finding again suggests that the support of nursing peers for collaboration, including having the necessary support to follow one's conscience, is highly important to nurses. Prior research has also examined the significance of the nursing peer relationship. Hart (2005) found that nurses were more likely to stay in their positions in a positive ethical work environment and this included the sharing of patient care responsibilities among other nursing team members. Similarly, Silen et al. (2012) revealed that nurses in their study expressed a need for nurses to support one another in the work group and that this included acceptance of the individual nurse's actions. The current Louisiana study adds to this evidence by demonstrating that nurses' perceptions of conscience are positively related to hospital ethical climate.

This study was based on the assumption that registered nurses are very aware of their beliefs about conscience and about the ethical climate of their work environments. Based on previous research, there was an assumption that the collection of demographic data would provide additional information regarding the potential differences in the sample population regarding the perceptions of conscience and perceptions of the ethical climate where they worked (Alkrisat, 2011; Glasberg et al., 2008; Saarnio et al., 2012). To measure these assumptions, research questions four through six were analyzed to determine if there were differences in the independent and dependent variables based on the demographics and job characteristics of the participants.

The aim of the fourth research question was to determine the relationship of hospital ethical climate on stress of conscience while controlling for certain demographics obtained during this study. The question was analyzed using a hierarchical

linear regression. The hypothesis for question four stated there is a positive, significant relationship between hospital ethical climate and stress of conscience among registered nurses when controlling for age, gender, specialization and number of years working as a nurse. As previously stated, the observations and perspectives of registered nurses play an important role in examining the cause of moral distress and identifying solutions to burnout, disengagement, nurse turnover and nurses leaving the profession. These perceptions provide insight to problems or behaviors that may lead to unresolved moral dilemmas causing distress in the nurse. The professional experiences, roles, and specialization perspectives can offer additional understanding on how conscience is perceived and utilized during moral dilemmas and whether this influences the ethical climate of a particular type of nursing unit. Moreover, demographic information may provide insight into the differences related to how stress of conscience may be experienced by the nurse (Ahlin et al., 2013; Saarnio et al., 2012; Tuveson et al., 2013).

It would be reasonable to assume that nurses with different ranges of age and professional experience who also work in a variety of nursing unit environments might vary in their views on factors that lead to a troubled conscience. However, results from the hierarchical linear regression indicated that gender, age, and work experience do not significantly predict stress of conscience. An additional 25% of variability in stress of conscience was explained by the inclusion of hospital ethical climate in the model beyond what is accounted for by demographic characteristics alone. Therefore, hospital ethical climate was found to be a significant predictor in the model. As units of increase occurred in hospital ethical climate suggesting a favorable work environment, the nurse

participants' stress of conscience scores decreased. The findings determined that the null hypothesis for research question four (H<sub>04</sub>) was rejected.

For research question five, demographic factors and job characteristics were analyzed. The hypothesis for the fifth research question stated there is an influence of demographic factors and job characteristics on stress of conscience among registered nurses. Factors associated with job characteristics in this study included years at present hospital, type of specialty nursing unit where the nurse participants worked, full time or part time work status, and type of nursing hours the nurses worked such as day or night shifts. The results of the multiple linear regressions were not significant and this indicated that demographic factors and job characteristics did not significantly predict stress of conscience. Thus the null hypothesis for research question five was not rejected. The findings from this study strongly support findings from previous studies (Alkrisat, 2011; Glasberg et al., 2008; Tuvevsson et al., 2012), which also reported that no significant relationships among demographic variables, job characteristics and stress of conscience were found.

A possible explanation for this finding is that the demographic and job descriptors associated with the nurse regarding types of work responsibilities and specialty care units may indeed be somewhat dissimilar. However these characteristics, while uniquely varied, are primarily external to the nursing experience of providing individualized patient care. Of importance is that nurses in this study implied the external demand of commitment to patients comes from their perceived internal responsibility and moral obligation to meet the needs of the patients and their family members. This was evident based on the participants' responses to the question, "Do you ever find yourself avoiding

patients or family members who need your help or support?” The majority of the respondents denied this occurrence, indicating the high priority of the nurses to their patients and families. However, when nurses perceive they are unable to meet the needs of their patients, which then compromises their own moral agency, an internal conflict may ensue. If left unresolved, a troubled conscience may be the result. In a study by Jensen and Liddell (2009), findings revealed that nurses see conscience as an act of duty for the patient’s sake and also view conscience as an act of courage. Their findings are relevant to this study as indicated by a significant number of participants who reported that they lack enough time to provide the care that the patient needs. Nearly 60% of the participants agreed that this gave them a very troubled conscience. As discussed in the Juthberg et al. (2010) study, this experience occurs because the nurse is keenly aware and sensitive to the ethical duty to the patient and the nurse experiences internal distress when this responsibility is not fulfilled.

For research question six, the overall model was again considered by examining the influence of the independent variables on the dependent variable beyond demographics and job characteristics. The hypothesis for the sixth research question stated there is a difference in how perceptions of conscience and ethical climate influence stress of conscience among registered nurses above and beyond associated demographics and job characteristics. The multiple linear regression results for the demographics and job characteristics did not significantly predict stress of conscience. For the second step of the data analysis, a hierarchical linear regression was completed. Findings revealed that stress of conscience could be explained by the inclusion of perception of conscience and hospital ethical climate in the model beyond what is accounted for by demographic



and job duties alone. Interestingly, perceptions of conscience and hospital ethical climate together were found to be significant predictors in the model, although hospital ethical climate had a stronger effect on the model than perceptions of conscience. With each unit increase in perceptions of conscience, participants' stress of conscience scores increased. However, with each unit of increase in hospital ethical climate, the participant's stress of conscience scores decreased.

As discussed by Juthberg et al. (2007), the relationships between perceptions of conscience and stress of conscience can demonstrate complex patterns. Yet when hospital ethical climate is added as part of the investigative inquiry, a clearer picture emerges. The utilization of a hierarchical regression model revealed a smaller predictive influence between perceptions of conscience and stress of conscience when the first two research questions, which sought a relationship by multiple regression analysis, did not. The overall statistical analysis shows that in isolation perceptions of conscience was not a predictive factor for stress of conscience in the nurses who were surveyed for this study. However, there is a predictive factor for perceptions of conscience on hospital ethical climate as supported in the third research question. Further, hospital ethical climate has a positive, significant relationship with stress of conscience as found in the first and fourth research questions, meaning that a positive ethical environment decreases the stress of conscience experience by the nurses in the environment. Thus, perceptions of conscience and hospital ethical climate when measured together do appear to have a predictive relationship on the nurse's stress of conscience individually and collectively. The null hypothesis for research question six ( $H_{06}$ ) was rejected.

The findings in this study reveal that for perceptions of conscience, the majority of the participants indicated the importance of following one's conscience no matter what others may think and that when they follow their consciences they develop as human beings. As noted previously, many of the participants agreed with the item, "God speaks to us through our conscience". A unique contrast however, was found in what the nurses appear to be actually experiencing in their workplaces as indicated by their responses to the three surveys. Scores were significantly lower for the item, "At my workplace, I can express my conscience". Additionally, several questions on the hospital ethical climate survey yielded low scores, including the items, "Conflict is openly dealt with here and not avoided" and "Nurses on this unit are able to openly disagree without fear of reprisal". Questions pursuant to the nurse-physician relationship, including the item, "Nurses and physicians here respect each other's opinions, even when they disagree about what they believe is best for the patient" were also scored low by the participants in this study. Perhaps most significant were the responses received on the Stress of Conscience questionnaire. While lacking time to provide needed care for the patient was highly scored, other items on this survey showed serious internal stressors as reported by the participants. With regard to external factors, nearly 65% stated that in the last six months, they had been forced to provide care for patients that felt wrong with almost 80% of those responding that it had given them a troubled conscience. A majority of the participants also reported witnessing patients being insulted and disrespected in the last six months with significant agreement that this had caused a troubled conscience.

Previous research findings indicate similar findings regarding collaboration gaps among nurses and their peers and physicians. In a study by Hamric and Blackhall (2007),

the researchers found that registered nurses experienced more moral distress and lower group effort than did physicians and had higher negative perceptions of the ethical climate. The nurses were also dissatisfied with the lack of patient care quality given on their units than were the doctors. Other studies have reported that low hospital and physician scores indicated that nurses were most likely to leave (Han, 2014; Suhonen et al., 2015). Additionally, Whitehead et al. (2015) found that poor team communication and lack of provider continuity were shared root causes for nurses as the leading cause for moral distress. Relating these findings to the study at hand, it appears that even though nurses expressed the importance of being able to follow their conscience, moral conflicts seem to exist due to the perceived suppression of opinions and poor team communication versus acting according to what their moral agency dictates. The challenge associated with the nurse participants indicating they had witnessed patients being insulted and disrespected illuminates a serious professional issue for all members of the healthcare team and potentially places the patient's safety at risk. It appears evident from this study, that nurses are experiencing a troubled conscience due to certain factors that affect, but possibly limit, their commitment to the patient and their desire to meet the patient's care needs. In ethical climates where nurses are unable to act on what their consciences dictates as the morally right thing to do, moral distress results (Corley, 2002; Pauly et al., 2009).

This study was designed using both the Ethical Climate and Moral Distress theories. The findings of this research investigation conducted among registered nurses working in Louisiana hospitals provide additional support to both frameworks. For the ethical theory sub-climate which was described in Victor and Cullen's (1988) Ethical

Climate Model, it was significant that the nurse participants appeared to connect their actions to their devout moral beliefs for ethical decisions. Additionally, caring, which was also discussed as a model concept, is essential to the undercurrent of the ethical climate and may decrease misbehaviors in the organization. For the moral distress theory, results from this study appeared to demonstrate that ethical climate does become evident in how the organization may treat patients and handle its conflicts (Corley et al., 2005). Similar to the theoretical constructs described by Corley (2002), findings from this study revealed when moral agency is disrupted, moral distress occurs, especially when ethical dilemmas are left without resolve. The need for a caring supportive environment that promotes open communication, an exchange of ideas and opinions, especially during distressful patient care situations, is not only necessary, but vital to promoting a positive, nurturing ethical climate of a nursing unit or ward.

The results of this study can add to the scientific knowledge base concerning how perceptions of conscience and hospital ethical climate influence stress of conscience in nurses. Based on findings that perceptions of conscience by nurses impact the ethical climate, increased understanding exists related to the importance of the ethical work environment and the role that nurses play in its overall influence. Additionally, this study determined a significant relationship between the hospital ethical climate and stress of conscience in nurses. The data supported that a more favorable and positive ethical climate decreases the stress of conscience nurses may experience. Findings also determined that the demographics and job characteristics of the nurse participants did not predict stress of conscience. Through the utilization of three instruments for this research,

findings also revealed a correlation between several factors which may contribute to poor ethical climates that lead to troubled conscience in registered nurses.

### **Implications for Practice**

The intent of this scientific inquiry was to explore the complex ethical environments where registered nurses work to generate more specific information than what was previously known. The hospital organization is one of complexity, yet there is a need to better understand the moral underpinnings that contribute to how ethical dilemmas are both experienced and addressed at all levels of the institution. This study has attempted to shine additional light on the significance of conscience and the ethical climate along with descriptions of the involved phenomena.

The implications of the results of the study are significant for healthcare organizations, hospital administrators and nurse managers. The individual and collective perceptions of conscience of their nurses all impact the overall ethical climate of the hospital and the ethical climate of the particular wards or departments within the hospital. The better or more positive the ethical climate of the hospital or unit is, the less nurses working there experience stress of conscience. That in turn further increases and enhances the ethical climate of the institution, reducing the results of stress of conscience including burnout, substandard patient care, and ultimately nurse turnover, which impacts the bottom line of the hospital organization.

The results illustrate the need for hospitals, administrators, and nurse managers to focus and enhance the hospital ethical climate by encouraging discussion, openness, and ongoing staff education in advance of problematic ethical issues. Further, providing services such as hospital support teams, which are designed to assist nurses to find moral

resolve with ethically complex patient situations, may decrease the long-term consequences associated with troubled conscience. Promoting an environment of trust that establishes the expectation of open dialogue without fear of retribution among nurses and their physician counterparts is critical for safe, high quality patient care.

In this study, over half of the participants reported having less than five years of professional experience. Yet the survey findings indicated that many appear to be experiencing a troubled conscience due to several factors and some appear to be unable to follow the dictates of their own consciences in light of the ethical environment where they work. Such tensions may be due to a lack of training or clinical experience to effectively address morally complex matters. A lack of understanding and poor professional communication may also exist related to the ethical commitments both nurses and physicians have related to their own practice. Further, real world ethics training and support could be limited or sparse both in academia and within the health care organization. As discussed by Malloy et al. (2009), it is important for both nursing and medical schools to do more to share knowledge regarding each other's professional ethics requirements and training (including codes of ethics) in their respective curricula. Misunderstanding will continue to cause difficulty for the physician-nurse dyad without a better understanding of each other's ethical commitment and scope of practice (Malloy et al., 2009).

The elimination of moral distress during ethical dilemmas encountered in the hospital environment may not be possible in light of the multiple complexities of patient care which exists in today's healthcare industry. However, given that nurses are the largest investment of hospital organizations, it is imperative that strategic solutions which

include nurses' involvement and input be prioritized at the unit or ward level to relieve the moral burden that nurses are experiencing as evidenced in the results of this study. Ethics education for staff members should include training on the significance of acting with moral courage and include discussion on procedures and support options for situations where conscientious objections may be voiced by the nurse due to a troubled conscience. Navigating morally complex issues can take time and thoughtful dialogue among all healthcare team members to resolve ethical conflicts (Rushton & Kurtz, 2015). The results of this study can provide insight into the importance of promoting and sustaining an ethical climate where these conversations may readily occur for the benefit of the staff and for the care and safety of the patients.

### **Limitations**

Although the results from this research showed support for previous studies, several limitations were associated with this investigation. One limitation was that the researcher did not have direct contact with the participants which prevented the opportunity to follow up on missing data. Participant self-selection may have biased the sample. A possible reason some of the potential participants chose not to finish the survey may have been due to being uncomfortable with memories of ethical situations in the workplace that invoked moral stress or resulted in moral distress. Additionally, some nurses may have chosen not to participate because they believed that they had little to contribute due to inexperience with, or limited recognition of, ethical dilemmas in their work environment.

Another limitation was a purposive, non-randomized sample was used to collect data in Louisiana, limiting the generalization of this study's findings beyond this

particular state. Generalizations to other geographical locations or other sample nurse populations may not be applicable. The sample population was also largely Caucasian and male nurses and those from other racial backgrounds were underrepresented. The majority of this sample population had religious affiliations associated with various sects of the Christian faith. A predominant number of nurses in this study also worked during the day time hours where other staff, nurse managers and physicians are more readily available for patient care support. Therefore, research findings may not be generalizable to other nurse populations with a different demographic makeup, religious affiliation or lack thereof, or to those who work during the late evening hours where immediate access to nurse managers and physicians for support may be more limited.

Lastly, this research utilized a descriptive correlational design and as such, causal connections could not be made. With correlational studies, manipulation of variables is not completed by the researcher which prevents identifying the effects of one variable on another (Bordens & Abbott, 2013). Due to this limitation, it was not possible within this study to demonstrate a cause and effect relationship between the hospital ethical climate, perceptions of conscience and stress of conscience.

### **Recommendations for Further Research**

Further studies should help to identify specific factors within the hospital work environment that could have adverse effects on nurses due to unresolved ethical stressors and prevent acts of moral courage. Based on the analysis of this study, several recommendations are offered for future nursing bioethics research on the use of conscience and ethical climate. The first recommendation is focused on obtaining a better understanding of the antecedents, such as nursing education, which contribute to moral



sensitivity training, including perceptions of conscience. A greater need exists to study, as an example, what nurses have been taught during their nursing training programs related to the use of conscience and recognition of moral distress symptoms to prepare and utilize specific skills to navigate the ethical challenges associated within the healthcare landscape.

One research opportunity is to explore through both qualitative and quantitative research methods how new nurses perceive their training programs in assisting them to recognize factors which could cause them to experience a stress of conscience, and if specific components of that preparation assisted in mitigating their moral suffering during those dilemmas. Second, another research area that should be explored is within nursing academia itself to determine what is taught regarding the interplay of the nurse's use of conscience and other possible contributory factors to the ethical climate where nurses are employed.

A longitudinal study could be conducted for future research to follow and compare new graduates who received specific training, such as through actual simulation experience, on moral decision-making and to identify how their perceptions of conscience, whether as an asset or burden, affected and assisted them to recognize a troubled conscience. Another research opportunity exists to explore how nurses may have viewed any changes in their perceptions of conscience over time during the matriculation of their education and training experience and how this may or may not have assisted them during real world experiences. These research opportunities could provide a possible baseline of understanding for the nursing scientific community and offer significant insight into whether nursing education is actually preparing graduates to

successfully confront and address future ethical dilemmas in the workplace that contribute to a stress of conscience. Such data may also provide nurse educators an opportunity to improve the nursing curricula and provide clinical ethics training that integrates actual simulated experiences throughout their training programs to build upon their critical thinking skills.

An additional recommendation would be that future studies on the relationship between perceptions of conscience, ethical climate and stress of conscience be expanded in other states beyond Louisiana using a larger and more diverse sample size. Continued study of these variables could then be generalized to a larger area and potentially include the national population of nurses. Further, other organizational climates outside of the acute care hospital setting should be investigated for comparative analysis of these variables.

Finally, future research should focus on identifying effective solutions that assist nurses dealing with a stress of conscience and moral distress. A fertile research opportunity for additional scientific data is presented to better understand if, how, and when nurses may utilize key resources such as the new 2015 edition of the American Nurses Association Professional Code of Ethics to assist them during ethical dilemmas that cause a conflict of conscience or to address problems associated with poor ethical climates. Whether the use of integrated skills learned during their academic training, or the utilization of professional resources such as the Code of Ethics, or employer provided ethics training, or whether nurses are mostly learning through trial and error experiences to deal with morally challenging dilemmas that lead to a troubled conscience is still relatively unknown. Thus an opportunity may exist to revise the instruments used for this

study or create a new one to better explore these conditions. By combining the pertinent findings from previous research work, this study and future related studies, vital tools and metrics that are grounded in best practices in nursing ethics can be designed and implemented starting in academia and throughout professional nursing practice.

### **Conclusion**

This quantitative study was conducted to determine if there is a positive, significant relationship between perceptions of conscience, hospital ethical climate and stress of conscience among registered nurses working in the acute care setting in Louisiana. The results of this study verified a significant relationship exists between perceptions of conscience and hospital ethical climate and between hospital ethical climate and stress of conscience. Perceptions of conscience and hospital ethical climate collectively were shown to also be related to stress of conscience. However no predictive relationship was found between nurse demographics and job characteristics on stress of conscience. These findings indicate the importance of nurses' beliefs about conscience and how, when perceived as an asset, burden and authority, it influences the ethical climate of a nursing unit or ward. The ethical climate also determines a stress of conscience in nurses and this study revealed the significance of the nurses' need to work in supportive, caring environments that promote and encourage them to follow what their consciences dictate.

Based on the results of this study, the conclusion can be drawn that perceptions of conscience in nursing contribute to the work environment. It does influence how ethically challenging dilemmas are experienced and are perceived and serves a vital underpinning which allows the nurse to act with moral courage. The important role of team

relationships was also duly noted as part of these findings. In ethical climates where nurses perceive that their ability to act on their consciences is suppressed by other nurses or physicians, a troubled conscience ensues. Moreover, the results of this study demonstrate that there is still a significant need to improve the interdisciplinary approach to patient care delivery where all professional contributions, opinions, and ideas foster better collaboration among healthcare team members. These interactions, including ongoing dialogue regarding ethical dilemmas which cause moral uncertainty and distress among the nursing staff are vital for the safety and clinical progress of patients under care. The importance of this and other related research findings from this study cannot afford to go unnoticed by hospital administrators and nurse managers. Their leadership role is critical to finding and implementing solutions that mitigate the negative consequences of poor ethical climates on nursing units and the resulting moral distress, burnout and exodus of nurses from their institutions and the nursing profession. These strategies will assist in combating the growing nursing shortage in the United States and the world.

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## APPENDIX A. STATEMENT OF ORIGINAL WORK

### Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

### Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the *APA Publication Manual*.

Learner name  
and date

Theresa A. Kyzar

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Mentor name

JULIA MOORE, PhD

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