The Relationship Between Nurses’ Ethical Reasoning with the Quality of Nursing Care

Abstract

Context: A high quality of nursing care is an important priority of nursing profession and directly associated with increased patient satisfaction. Evidence shows that ethical professional issues are challenging with significant influences on the quality of nursing care. Aims: The aim of this study was to determine how quality of patient care relates to the nurses’ ethical reasoning as viewed by patients in medical wards. Settings and Design: This study used a descriptive correlational design. Subjects and Methods: Data collection tools included a Nursing Dilemma Test and Quality Patient Care Scale. In total, 180 hospitalized patients and 180 nurses who worked in medical wards of Hospitals in 2017 were enrolled. Sample selection was done by the census method. Statistical Analysis Used: Data were analyzed by the SPSS software version 22. Results: The means score for nurses’ quality care was 91.71 ± 14.81. Furthermore, the mean score for ethical reasoning among nurses was at an average level of 45.07 ± 6.12. There was no significant relationship between the quality of care and nurse’s ethical reasoning (P > 0.05). Conclusions: The results revealed that factors other than ethical reasoning of nurses are related to quality of care. Furthermore, nurses showed an average ability in ethical reasoning. So to improve this situation, healthcare system administrators can offer professional training programs to increase ethical sensitivity and reasoning among the nurses who face daily ethical issues.

Keywords: Ethical reasoning, Iran, nurses, patients, quality of health care

Introduction

Quality nursing care is a fundamental component of health care services.1,2 Although care is defined rather differently among the experts in nursing profession, nevertheless, majority of nurses are aware that care refers to the tasks beyond a series of skilled steps done for a patient.3 Providing patient care is an important part of nursing as an art of giving, where nurses offer personal, social, mental, and emotional assistance to reach a desired and holistic outcome.3,4 To clarify the meaning of quality nursing care, patients’ opinions should be considered. Furthermore, the primary and most important index of quality care should be assessed and measured by nurses,4 as the largest group of health-care providers with the highest degree of patient contacts.5,6 Therefore, in addition to the valuable patients’ views, tools are necessary to measure the quality of nursing care as practicing nurses perceive the given patient care.1

Currently, healthcare settings are changing at a fast pace and nurses encounter various ethical issues on daily basis.7,8 Some of these issues are the excessive use of technical and medicinal interventions in patient care,9 a change in nursing concepts and healthcare intervention necessities, an increased dilemma in elder and end-of-life care,10 clients’ refusal to adhere to the treatment and regards for the patients’ bill of rights. These are only a few examples of the frequently occurring nursing ethical issues as professional codes are conducts gain higher importance in daily practice.11 These ethical issues continue to challenge nurses, as the largest team of care providers and demand clear understanding and considerations.12

Literature indicates that although nurses’ awareness of their ethical responsibilities in providing quality care is increasing, the challenges for recognizing how to make the best ethical decisions to solve the problems are also increasing.13 Having the skills and competency to resolve ethical conflicts seem indispensable for high-quality nursing care.9 Ethical reasoning, as a fundamental

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concept refers to an individual’s ability to choose one solution to solve ethical problems from among variety of choices and for various individuals, based on their knowledge and conscience, and for different reasons derived from ethical decision making skills. Individuals’ reasoning about accuracy and inaccuracy of the tasks has a profound effect on the ethical climate of work place and quality and quantity of the practice, as Rest et al. suggested the four-component pattern including ethical reasoning, moral sensitivity, moral motivation and moral characters, to be the ethical reasoning principle criteria for implementation of a moral practice. According to the Kohlberg’s theory, the ethical reasoning development occurs at three main levels, with every level having two stages include preconventional level, conventional level, and postconventional level. Zirak et al. show that 75% of nurses reasoned at conventional and postconventional stages. Similarly, De Casterle in Belgium indicated that novice nurses mainly reasoned at conventional stage rather than postconventional; however, experienced nurses mostly did ethical reasoning at postconventional stage. Researchers believe that in nursing profession, the importance of care ethics exceeds therapeutic considerations as manifested by prepared professional codes of ethics. However, having knowledge about ethical codes does not guarantee their proper implementation, as some studies have reported medical and nursing students’ unethical behaviors toward patients at teaching hospitals. Study results in Iran show unsatisfactory utilization rate of ethical codes in clinical decision-making and nurses’ inability to incorporate ethical knowledge in real clinical setting. The lack of ethical reasoning skills has excluded the majority of nurses from having a significant role in the process of decision-making and hindered their daily practice routine. Khaki et al. reported that patients were satisfied with the quality of nursing care and the nurses’ ethical decision-making; however, researchers found no relationship between observing ethical codes and the quality of care. Nonetheless, Freda Ganz and Berkovitz showed that there was an inverse correlation between repetition of moral dilemmas and nurses’ competency, care quality and meeting patients’ needs.

Subjects and Methods
Design and setting
This is a descriptive correlational study that was performed in 2017 at the internal wards of teaching hospitals (Imam Reza, Madani, Sina, and Razi hospitals) in Tabriz, Iran. Researchers recruited all the actively employed nurses and patients admitted to these Hospitals. The inclusion criteria for nurses were, having a bachelor degree or master degree in nursing, having clinical experience for at least 6 months, being employed at one of the internal wards and having no previous involvement in ethics workshop. The inclusion criteria for patients were, being at least 18 years old, receiving nursing care in the internal ward, having no known cognitive or mental disorders, and willing to participate in the research study. The exclusion criteria included being unwilling to participate in the study for both nurses and patients.

Sampling
The sample size was determined using the methods by Koohi et al., titled “identifying the relationship between ethical reasoning score and nurses’ personal-occupational characteristics’ carried out in 2015 with standard deviation (SD) = 6.72. The sample size was calculated as 171 considering \( \alpha = 0.05 \) and \( d = 0.15 \). To adjust for the limited number of nurses in internal wards, census method was used. The researchers referred to the internal ward of the hospitals in different work shifts (morning, evening, and night) and selected qualified nurses. There were 10 internal wards in four hospitals, and in each shift, 3 nurses were taking care of patients. Finally, the total of 180 qualified nurses included in the study during the 2 weeks. One patient assigned to each recruited nurse was chosen through random sampling method. Since providing care in intended wards was not through case method, it was explained to the patients that while completing the questionnaire they ought not to focus only on the specific nurse that provided care and consider every nurse assigned to their care. Moreover, patients were reminded that the questionnaire was merely for the evaluation of nurses’ caring behaviors and did not include other personnel’s behaviors. It is noteworthy that nurses in administrative roles were not included in the study sample.

Data collection
Demographic survey questionnaire obtained information on nurses and patients. Other tools included Nursing Dilemma Test (NDT) according to Kohlberg’s theory and Care Quality questionnaire (Quality of Patient Care Scale [QUALPAC]). Standard demographic data for nurses consisted of age, sex, marital status, educational degree, work experience, work shifts, name of the hospital, residency type, employment status, and experience with critical events. The questionnaire for patients asked about age, sex, marital status, education level, history and duration of hospital stay, and the employment status.
Nurses' ethical reasoning and quality of care

In this study, 180 nurses and 180 patients from internal wards at various teaching hospitals in XXX, Iran were assessed on the quality of nursing care and nurses' ethical decision-making skills. Among the nurses, 96% were female and 45.6% of patients were male. In total, 65.6% of nurses and 85.6% of patients were married. The mean age of nurses was 32.42 ± 5.6 years, and their mean work experience was 7.6 ± 5.4 years. The mean age of patients was 54.18 ± 17.31 years.

Data analysis

Data from all the samples were analyzed using the SPSS software version 22 (SPSS for Windows, SPSS Inc., Chicago, Illinois, USA) for descriptive statistics such as frequency, percentage, mean, and SD as well as inferential statistics such as Pearson correlation coefficient. A confidence interval of 95% and probability of \( P < 0.05 \) were considered statistically significant using statistical tests.

Results

In this study, the total score of the nurses' quality of care from the patients' viewpoint was 91.71 ± 14.81 and 42.2% of patients reported that nursing quality of care was undesirable in psycho-social dimension and 43.3% in communication dimension. Table 3 shows the frequency, percentage; mean and SD of nursing care quality and its dimension from the patients’ point of view. The results showed that the mean score for nurses’ ethical reasoning

Ethical considerations

After the study design was reviewed and approved at the university, a permit was issued by the Research Ethics Committee from Tabriz University of Medical Sciences (Ethical Approval No: IR.TBZMED.REC.1395.500). Before starting the research process, institutional authorities concurred and all nurses were informed about the study purposes, questionnaires, confidentiality, and the participants’ liberty to join or withdrawal from the study. Informed consent was obtained from all participants and questionnaires were completed by nurses during various shifts. Afterward, the researcher introduced herself to the patients at the internal ward and explained the study purpose, answered questions and obtained a written consent form. Questionnaires on the care quality from patients’ point of view were distributed and later face-to-face interviews were conducted.

Face and content validity of the questionnaire were confirmed by Zirak et al.[19] In order to use the Iranian version of this questionnaire, permission was obtained from Mrs. Borhani et al.[25] by correspondence through E-mail. Researchers in the present study re-evaluated the questionnaire’s reliability by using a pilot test-retest among 30 participants within 10 days and established a reliability coefficient of 0.80. In order to identify face and content validity, the questionnaire was also reviewed by 10 professors at the XXX University of Medical Sciences and revisions were applied.

Nursing care quality was assessed using the QUALPAC. This tool has been used frequently since 1993 in countries such as USA, UK, and Nigeria. It has similarly been used in Iran.[34] In this study, we used a modified version by Khoshkho[35] and permission to use this questionnaire was obtained from the authors. This questionnaire with 41 items assessed the care quality. From 41 items, 28 and 13 items assessed mental-social and communicational aspects, respectively. The scoring was based on Likert scale scoring (rarely = 1, sometimes = 2, and often = 3). The score range was between 41 and 123. The scores of 41–68 represented undesirable care, 69–95 rather desirable and 96–123 optimum care. The mentioned questionnaire was investigated in XXX during 2003 and was conformed to the Iranian culture.[35] In order to identify the face and content validity, the questionnaire was also reviewed by 10 professors at the XXX University of Medical Sciences and their modifications were applied. In the study by Khaki et al. in Iran, the reliability of the questionnaire was confirmed by Cronbach’s Alpha value of 97%.[27] To obtain the questionnaire’s reliability, 20 interviews were conducted with patients as a pilot study and internal consistency were calculated through Cronbach’s alpha value of 0.96.

Data from all the samples were analyzed using the SPSS software version 22 (SPSS for Windows, SPSS Inc., Chicago, Illinois, USA) for descriptive statistics such as frequency, percentage, mean, and SD as well as inferential statistics such as Pearson correlation coefficient. A confidence interval of 95% and probability of \( P < 0.05 \) were considered statistically significant using statistical tests.

Results

In this study, 180 nurses and 180 patients from internal wards at various teaching hospitals in XXX, Iran were assessed on the quality of nursing care and nurses’ ethical decision-making skills. Among the nurses, 96% were female and 45.6% of patients were male. In total, 65.6% of nurses and 85.6% of patients were married. The mean age of nurses was 32.42 ± 5.6 years, and their mean work experience was 7.6 ± 5.4 years. The mean age of patients was 54.18 ± 17.31 years. Table 1 shows demographic characteristics of participants (nurses and patients). Furthermore, the results of this study showed that there were no significant differences between ethical reasoning mean scores of nurses based on the type of their demographic characteristics [Table 2].

In this study, the total score of the nurses’ quality of care from the patients’ viewpoint was 91.71 ± 14.81 and 42.2% of patients reported that nursing quality of care was undesirable in psycho-social dimension and 43.3% in communication dimension. Table 3 shows the frequency, percentage; mean and SD of nursing care quality and its dimension from the patients’ point of view. The results showed that the mean score for nurses’ ethical reasoning
Table 1: Demographic characteristics of patients and nurses

| Type of variable | Nurses (n=180) | Patients (n=180) |
|------------------|----------------|------------------|
|                  | n (%)          |                  |
| Gender           |                | Gender           |
| Male             | 6 (3.3)        | Male             |
| Female           | 174 (96.7)     | Female           |
| Educational level|                | Marital status   |
| Bachelor         | 175 (97.2)     | Single           |
| Master           | 5 (2.8)        | Married          |
| Marital status   |                | Divorced         |
| Single           | 60 (33.3)      | Educational level|
| Married          | 118 (65.6)     | Illiterate       |
| Divorced         | 2 (1.1)        | Elementary       |
| Location         |                | Diploma          |
| Native           | 149 (82.8)     | Academic         |
| Nonnative        | 31 (17.2)      | Hospitalization history |
| Experience about critical event | | |
| Yes              | 49 (27.2)      | Yes              |
| No               | 131 (72.8)     | No               |
| Age (years), mean±SD | 32.42±5.6    | Age (years), mean±SD |
| Work experience (years), mean±SD | 7.6±5.4       | Duration of hospitalization |
|                  |                | 9.01±5.17        |
|                  | (Mean±SD)      |                  |
|                  |                |                  |
| Gender           |                |                  |
| Male             | 5.41±44.93     | P=0.576          |
| Female           | 6.83±45.21     | P=0.656          |
| Educational level|                |                  |
| Bachelor         | 6.04±45.12     | P=0.97           |
| Master           | 7.39±46.36     | P=0.331          |
| Marital status   |                |                  |
| Single           | 5.44±44.7      | F=0.14           |
| Married          | 6.25±45.24     | P=0.869          |
| Divorced         | 1.41±45.01     |                  |
| Location         |                |                  |
| Native           | 5.78±45.42     | t=1.70           |
| Nonnative        | 6.08±43.38     | P=0.089          |
| Experience about critical event | | |
| Yes              | 5.73±45.28     | t=0.28           |
| No               | 6.21±44.99     | P=0.774          |
| Age (years)      |                |                  |
| 21-30            | 5.62±45.35     | F=1.06           |
| 31-40            | 6.35±44.69     | P=0.742          |
| 41-50            | 5.85±46.07     |                  |
| Work experience (years) |          |                  |
| 1-10             | 7.23±43.71     | F=1.15           |
| 11-20            | 6.30±45.06     | P=0.316          |
| 21-30            | 6.12±45.41     |                  |
|                  | (Mean±SD)      |                  |
|                  |                |                  |
| SD: Standard deviation |                |                  |

Table 2: Comparison of mean scores of nurses’ ethical reasoning based on their demographic characteristics

| Variables                        | Ethical reasoning (Mean±SD) | P     |
|----------------------------------|----------------------------|-------|
| Gender                           |                           |       |
| Male                             | 5.41±44.93                | t=0.576, |
| Female                           | 6.83±45.21                | P=0.656 |
| Educational level                |                           |       |
| Bachelor                         | 6.04±45.12                | t=0.97, |
| Master                           | 7.39±46.36                | P=0.331 |
| Marital status                   |                           |       |
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| Location                         |                           |       |
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| 41-50                            | 5.85±46.07                |       |
| Work experience (years)          |                           |       |
| 1-10                             | 7.23±43.71                | F=1.15, |
| 11-20                            | 6.30±45.06                | P=0.316 |
| 21-30                            | 6.12±45.41                |       |
| Statistical significance <0.05.  | SD: Standard deviation    |       |

Researchers found that nursing care quality was perceived at the optimum level by the majority of patients. In a similar study, Neishabory et al. reported a desirable quality of nursing care by patients.[33] Khaki et al. reported the quality of nursing care with regard to communication and psycho-social aspects, were optimal and rather optimal respectively.[27] However, Hong Zhao, Ahmad and Shannon reported a high mean score for the quality nursing care from patients’ point of view.[36‑38] The possible factors affecting these differences could be related to the health-care systems, public wards in teaching hospitals and care being provided under a functional method. In a functional method, the patient is not considered as a single unit and there is a probability that some of the patients’ needs are overlooked. This might influence the patients’ perception of quality of care. In addition, these differences might be rooted in cultural and social differences; different levels of training at human resources for employees; and therapeutic centers used in their studies. Besides, patients are more aware of their rights for communication, psycho and social care. Thus, results are indicating increased patient sensitivity towards quality and quantity of care.

We found that nurses’ mean score for ethical reasoning was average (45.07 ± 6.12). Investigations on this field, both inside and outside of Iran, show different levels of ethical reasoning, as Zirak et al. in 2012 reported a correlation between the mean scores of quality of care and its dimensions from the patients’ point of view and nurse’s ethical reasoning (P > 0.05). Table 5 shows the details.
Nurses' ethical reasoning and quality of care

| Variables                        | Mean±SD     | 95% CI      | Desirable, n (%) | Somewhat desirable, n (%) | Undesirable, n (%) |
|----------------------------------|-------------|-------------|------------------|---------------------------|-------------------|
| Psychosocial dimension           | 61.80±10.0  | 60.53-62.14 | 76 (42.2)        | 97 (53.8)                 | 7 (3.8)           |
| Communication dimension          | 29.90±5.30  | 29.20-30.54 | 78 (43.3)        | 99 (55.0)                 | 3 (1.6)           |
| Total quality of care            | 91.71±14.81 | 90.73-92.46 | 79 (43.8)        | 94 (52.2)                 | 9 (5.0)           |

SD: Standard deviation, CI: Confidence interval

| Ethical reasoning levels         | Mean±SD     | 95% CI      |
|----------------------------------|-------------|-------------|
| Preconventional level            | 44.12±6.19  | 43.08-44.89 |
| Conventional level               | 45.10±5.93  | 45.05-45.48 |
| Postconventional level           | 46.02±6.25  | 45.86-46.14 |
| Total mean score                 | 45.07±6.12  | 45.04-46.14 |

SD: Standard deviation, CI: Confidence interval

the level of ethical reasoning among nurses in Tabriz was (46.67 ± 4.68).[19] Moreover, in a study by Koohi et al., the nurses’ mean score for ethical reasoning was (40.81 ± 6.72).[16] Another score was reported as (51.74 ± 5.9) and (47.89 ± 6.72) by Ham and Cerit and Dinç, respectively.[19,40] Direct or indirect differences in the mean scores for ethical reasoning might be related to the factors such as the level of education, cultural and social backgrounds, nurses’ clinical experiences and rules and regulations at work place.[41] Similarly, Goethals in his study referred to some factors such as values, beliefs, ideas, staff’s skills and other aspects of nurses’ ethical behavior.[15] It seems that, in order to improve nurses’ ethical reasoning, the affecting factors could be investigated and identified through further experimental studies.

In reference to our results, other studies in and outside of Iran have reported that majority of nurses reasoned at the conventional and postconventional levels.[16,19,20,40] Similarly, according to Zirak et al., nursing students and newly employed nurses should strive to reach a conventional and post conventional level of ethical reasoning.[14] There is a gap between the existing and an optimal level of postconventional ethical reasoning and there should be opportunities for nurses to improve their ethical reasoning skills toward post conventional level[7] through appropriate educational programs.[39] An important reason for ethics training is to enhance nurses’ commitment to high-quality of patient care.[7] However, Iranian nurses have had limited access to ethical training to adequately utilize ethical knowledge in clinical decision makings in practice with confidence.[43] Regarding the role of ethical education and knowledge for developing ethical reasoning,[45,46] it could be possible to provide further training to increase mean scores for critical thinking in nursing education and improve nurses’ ethical reasoning skill through appropriate and novel approaches with scenarios and models in different educational programs.[45]

Here, researchers found no statistical significance in relating nurses’ ethical reasoning and patients’ perception of nursing care quality. Therefore, it can be concluded that there may be other factors than ethical reasoning that affect the quality of nursing care such as attitudes, values and beliefs. Consistent with the results of our study, Khaki et al. found no significant relationship between observing ethical codes and the quality of nursing care.[27] Therefore, the process of ethical reasoning among nurses appears to be a part of their moral performance and ethical behavior.[15] Meaning, the ability to reason ethically in itself does not guarantee providing ethical and professional care. According to Kohlberg’s theory, individuals might have ideal attitudes toward ethics; however, their behavior might not be necessarily in harmony with those attitudes. As a result, a complete agreement between ethical judgment and ethical performance is not expected.[16] Cerit and Dinç alike found a weak relationship between nurses’ ethical reasoning score and their professional behavior.[40] On the other hand, when faced with challenging ethical situations, nurses are not the only individuals who make decisions and numerous factors might influence their decisions.[39] Accordingly, it seems that nurses’ ethical behavior in social environments needs to be analyzed.[47] Some studies indicate that supports, organizational environment, and positive ethical climate have a significant effect on nurses’ ethical reasoning and practice and are greatly influential in effective resistance against ethical misconduct.[48,49]

Although ethical reasoning is an important factor for identifying ethical challenges, making the right decisions and providing moral care for the patients seems as appropriate part of ethical reasoning in itself and does not guarantee a right decision making process in a real life situation. It could be concluded that nurses’ opportunity to implement the decisions often diminishes when they encounter circumstantial and complicated situations and their ability to act based on the personal values and norms becomes restricted; as a result, a gap is created between ideal moral decision and an actual ethical behavior.[15] Therefore, policy-makers in healthcare system should change or modify the challenges ahead for nurses and find ways to improve nurses’ moral practice, along with developing technology, training for comprehensive and holistic care.

Using questionnaire was one the main limitations of this study. Nurses’ personal and attitudinal differences and their perception of ethical reasoning could influence their responses, which was beyond the researcher’s control.
Subjects’ responses were based on their level of perception not on their actual practice and it might have had effect on the accuracy of the results. The researcher, similarly, had no control over this issue. In the present study, the level of ethical reasoning was assessed from the individuals’ perspective; consequently, their occupational and personal condition might have had an effect on their responses to the research questions, which was beyond the researcher’s control and it is required that alternative methods such as qualitative study of the effect of nurses’ lived experiences on their level of ethical reasoning be used for further investigation. Another limitation that was beyond the researcher’s control was having mostly female nurses and patients that limited the males’ perspectives. Therefore, it is suggested that this study be conducted comparing the two genders. This was a cross-sectional study carried out over a specific period of time which might have produced different results if conducted in another time span. This study was limited to internal wards; accordingly, the results might not be generalizable to other units. Given the relevance of variables such as quality of nursing care to contextual culture of patients, it is recommended that this study be conducted elsewhere in the world with different cultures.

### Ethical clearance

Ethical Clearance was obtained from the Ethical Committee of Tabriz University of Medical Sciences.

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### Conflicts of interest

There are no conflicts of interest.

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### Conclusions

The results showed that the quality of nursing care had no significant relationship with nurses’ ethical reasoning. In addition, the level of ethical reasoning ability of the nurses in this study was moderate. Based on the results, it can be concluded that there may be other factors than ethical reasoning influence the quality of care such as attitudes, values, and beliefs. Regarding the role of ethical reasoning in clinical decision makings and its effects on different healthcare units, it might be appropriate to implement continuous educational programs centered on ethical problems to improve the level of ethical reasoning among nurses. Since one of the criteria for nurses’ professional qualifications is reasoning about moral issues, preparing management and educational programs for improving nurses’ professional qualifications, and implementing short-term and mid-term scientific and practical educations could help enable health-care staff to utilize critical thinking, decision making, clinical judgment, and ethical reasoning in the healthcare profession. Nursing education programs can first emphasize human values and then focus on valuable ethical nursing practice to avoid unethical negative effect on the nursing profession with grave risk to patients’ well-being.

### Table 5: Relationship between nurses’ moral reasoning and quality of care from the viewpoint of patients

| Variables                  | Preconventional level | Conventional level | Postconventional level | Nurses’ ethical reasoning |
|----------------------------|-----------------------|--------------------|------------------------|--------------------------|
| Total score of quality care| −0.39 (0.18)          | 0.26 (0.11)        | 0.10 (0.27)            | 0.32 (0.08)              |
| Psychosocial dimension     | −0.15 (0.62)          | 0.16 (0.09)        | 0.28 (0.11)            | 0.17 (0.23)              |
| Communicational dimension  | −0.42 (0.07)          | 0.21 (0.14)        | 0.17 (0.39)            | 0.25 (0.16)              |

Correlation is significant at the P<0.05 level (two-tailed)
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