

Simulations in nursing practice: toward authentic leadership

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Aim This study explore nurses' ethical decision-making in team simulations in order to identify the benefits of these simulations for authentic leadership.

Background While previous studies have indicated that team simulations may improve ethics in the workplace by reducing the number of errors, those studies focused mainly on clinical aspects and not on nurses' ethical experiences or on the benefits for authentic leadership.

Methods Fifty nurses from 10 health institutions in central Israel participated in the study. Data about nurses' ethical experiences were collected from 10 teams. Qualitative data analysis based on Grounded Theory was applied, using the ATLAS.TI 5.0 software package.

Findings Simulation findings suggest four main benefits that reflect the underlying components of authentic leadership: self-awareness, relational transparency, balanced information processing and internalized moral perspective.

Conclusions Team-based simulation as a training tool may lead to authentic leadership among nurses.

Implications for nursing management Nursing management should incorporate team simulations into nursing practice to help resolve power conflicts and to develop authentic leadership in nursing. Consequently, errors will decrease, patients' safety will increase and optimal treatment will be provided.

Keywords: authentic leadership, ethical dilemmas, health care, nursing, team-based-simulation

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Introduction

Simulation has been used outside healthcare for decades to study concepts of risk-free training and to practice critical thinking skills (Rauen 2004). The use of simulation in professional health care has expanded with the development of technologies that provide complex interactive platforms to support highly realistic simulations (Grenvik & Schaefer 2004). A literature review of 18 articles from 1991 to 2005 on the use of patient

simulators suggests evidence of faster skill acquisition and performance improvements (Academic Health Council PEIF Project 2007). The use of simulation in nursing practice has also been employed in a number of areas over the years, including intensive care (Henry & Waltmire 1992), child health (Krawczak & Bersky 1995) and medical-surgical nursing (Medley & Horne 2005). Computer-based simulations have also been employed in decision-making and team work situations in order to provide practice of clinical skills in simulation

settings (NCSBN Research Brief 2009). Thus, simulations can provide effective tools for training and improving performance in health institutions.

Aim

Studies have shown that simulations of ethical dilemmas can improve the effectiveness of health institutions by reducing the number of errors, increasing patients' safety, and providing optimal treatment (Ziv *et al.* 2003). Nonetheless, no study to date has ever focused primarily on simulations that were based on nurses' ethical experiences. Instead, most studies focused on the clinical aspects of these simulations (Academic Health Council PEIF Project 2007). Therefore, the purpose of this study was to examine nurses' ethical decision-making as manifested in team-based simulations and to explore the benefits that such simulations have for authentic leadership.

Background

The conceptual framework for the present study is grounded in the literature on ethics, authentic leadership and on team-based simulation in nursing.

Ethics in nursing

Ethical conduct in nursing is important because it affects the well-being of patients as well as the ability to maintain a staff that is productive and committed to quality care (Weiner *et al.* 2002, Filipova 2009).

The Joint Commission on Accreditation of Health Care Organizations and the United States Sentencing Commission have introduced standards to ensure the integrity of ethical decision-making throughout health-care institutions (Silverman 2002). The American Nurses Association has also developed guidelines for nurses' participation and leadership in ethical decision-making (American Nurses Association 1986). The Israeli nurses code of ethics (Israeli Nurses Association Code of Ethics 2004), which is very similar to the International Council of Nurses Code (2006), includes ethical issues such as providing professional and safe care without discrimination in accordance with patients' cultural needs and supplying full information regarding diagnosis, care options and outcomes. It is therefore expected that nursing students will receive systematic training in ethical issues related to nursing. Unfortunately, a great number of nurses have not been exposed sufficiently to proper standards of ethical conduct (Deshpande & Joseph 2009). Thus, many nurses

around the world find themselves powerless in dealing with ethical dilemmas at work (Sieloff 2003).

The Royal College of Nursing (1997) defines an ethical dilemma as a choice that involves differing personal principles and beliefs. Nurses encounter many situations in their daily work that require judgements other than clinical judgements, that is, judgements related to what is 'right' or 'good' (Wolf & Zuzelo 2006). The most common ethical dilemmas relate to patient care, duty to report, autonomy and professional standards. Patient care refers to the professional health care given to patients (Cronqvist *et al.* 2004). Duty to report refers to the commitment of health professionals to protect their patients' health even at the expense of their friendship with their colleagues (Shapira-Lishchinsky 2010). Autonomy refers to the rights of the individual-respect for the individual's right (nurse or patient) to choose and make informed decisions (Tomey 2009). Professional standards refer to the obligation to provide equal opportunity to all without discrimination, both to colleagues and patients (Matt 2008). In this study we will try to find out whether and how team-based simulations (TBS) may help nurses to deal with their ethical dilemmas and thus to develop their authentic leadership.

Ethical decision-making in teams

An ethical decision has been defined as 'a decision in which all stakeholders have been accorded intrinsic value by the decision-maker' (Christensen & Kohls 2003, p. 332). An ethical decision is then, according to this definition, a team process. A team process, for example, might be holding a discussion at a nurses' staff meeting about the criteria for distributing medicine in the ward without the doctor's written orders. According to Israeli law, in most cases, this is against the rules (Section 59 [1] A of Israel's Physician Ordinance 1976). However, doctors regularly pressure nurses to distribute medicines based on over-the-phone instructions.

This example reflects the power conflict in the nurse-doctor dyad, a conflict between two different status levels (Vivar 2006). In the nursing context, the word 'power' usually has negative connotations: it is associated with authoritative leadership, with one person restricting another's freedom of action (Kuokkanen & Leino-Kilpi 2000). In Israel, nurses are encouraged to obtain an academic degree to advance on the managerial ladder (Ehrenfeld *et al.* 2007). In most cases, they still need a doctor's order to perform simple procedures. The medical hegemony continues to render nurses unable to substantially influence the decision-making

process (Greenberger *et al.* 2005). Thus, although Israeli nurses do have a code of ethics (Israeli Nurses Association Code of Ethics 2004), they often find themselves crossing over to the professional territory of physicians without statutory authorization (Riba *et al.* 2004).

Making difficult ethical decisions in teams is a critical component of success for today's nurses because most nurses' activities today are based on teamwork (Drach-Zahavy & Baron-Epel 2006). Therefore, nurses need appropriate team training in order to make ethical judgements under stressful moral conditions (Vanlaere & Gastmans 2007). This study examines how training by simulation may assist nurses in making ethical judgements and becoming authentic leaders.

Team-based simulations (TBS) in nursing

Salas *et al.* (2009) define simulation as 'any artificial or synthetic environment that is created to manage an individual's (or team's) experiences with reality' (p. 560). In practical terms, simulation is a training method in which participants perform tasks in lifelike circumstances and receive instant feedback from observers in order to assist them in improving coping skills (Moratis *et al.* 2006). Thus, TBS can provide nurses with the best training and most constructive learning experience as it provides an optimal environment for active and critical learning (Keys & Wolfe 1990).

Toward nurses' authentic leadership

Authentic leadership in nursing (Avolio *et al.* 2004) is described as the root component of effective leadership required to build an ethical and healthier work environment in order to promote excellence in care. According to Gardner *et al.* (2005), there are four components of authentic leadership: (1) 'Balanced processing', which is the willingness objectively to analyse relevant data and to explore other views before making a decision. (2) 'Internalized moral perspective', which is the internal moral standards that guide a person's actions so that they are consistent with his/her values. (3) 'Relational transparency', which is the sharing of information through honest communication with others, and (4) 'Self-awareness', which is the understanding of a person's strengths, weaknesses and the way he/she makes sense of the world (Kernis 2003). So far, there has been little empirical research to understand the mechanisms of authentic leadership in healthcare set-

tings. This study will try to identify the benefits of TBS for authentic leadership.

Method

Participants

The participants were 50 nurses from 10 Israeli hospitals and HMOs in the center of Israel, varying in size and type (e.g. public hospitals, private hospitals, ultra-orthodox hospitals, state-run religious hospitals, HMOs). The nurses came from different specialties (e.g. gynaecology, internal medicine, neonatal, surgery), which resulted in a sample representing a cross-section of practising nurses in Israeli hospitals and HMOs. The selection of hospitals and HMOs was pragmatic, based on institutions in which the nurses were willing and available to participate.

Eighty-five percent of the participants were women. The participants' mean age was 38.48 years (SD = 7.50). The job seniority was 13.86 years (SD = 7.42); 75% of the nurses had tenure, and the others were employed through temporary contracts. These background characteristics are typical of the Israeli health system (Israeli Central Bureau of Statistics 2010), indicating that the sampling of respondents accurately represented the nursing population in Israel.

Data collection

The data examined in this paper were collected during 2010. Ethical considerations were made on the basis of the guidelines taken from the Ethical Principles of Psychologists and Code of Conduct (2002). Permission to conduct the research was first obtained from the Institutional Review Board in the lead-researcher's university and then from the ethics committees in the health institutions that were participating in the study. Then, group information meetings were called, in which research assistants informed nurses that they were collecting data in order to study the benefits of TBS based on their ethical experiences. Participating nurses were informed and ensured that when the results of the study were published, their statements during the simulations would not be traced back to them. They also received a formal letter describing the goals of the study, the pledge to preserve anonymity and confidentiality, and their right to withdraw from the research at any time. This assurance was a contributing factor in the willingness of nurses to participate. Nurses who volunteered for the study signed an informed consent, including a specific consent to being video-recorded.

Additional ethical considerations

The author was not involved in the team simulations either as a mentor or a preceptor, thus there was no conflict of interest or dependence between the participants and the researcher.

Procedure

The nurses were randomly divided into 10 groups of five. The study consisted of 50 simulation sessions, each simulation session lasting 45 minutes (generally, a 10 minute period of role playing and 35 minutes of discussion). Each simulation meeting included 2–3 simulation sessions, which meant that each simulation group met twice during the research.

All sessions were held in a room at one of the biggest hospitals in the centre of Israel. The room was technologically equipped to videotape the simulations and discussions, and to screen the videos so the nurses could later view and discuss them. A video technician was responsible for the videotaping and the screening.

The study was performed via a three-phase design:

- *Generating a pool of ethical dilemmas for TBS.* At the beginning of the research, each participant was asked to describe one ethical event that had occurred while working in a team on the hospital ward/HMO. This research approach is derived from Hill and Semler's study (2001) which claims that simulation training can most effectively increase learning transfer and performance when it focuses on the learners' own experiences. Participants e-mailed their personal cases to the research coordinator, who then re-formulated them without changing their contents and adapted them to fit the structure of role-playing for team-based simulations.
- *Simulating the ethical events.* The research coordinator randomly chose the event/s that the participants would simulate in each session. The nurses who participated in the role-playing were chosen randomly in each session by the research assistants conducting the simulations. During the role-playing, there were no more than four nurses participating in any given simulation. The remaining nurses were asked to observe silently until the role-playing ended. Observers usually sat in a circle around the role-players.
- *Viewing the videotaped simulations, discussing and analysing the emerging ethical dilemmas.* As soon as the simulation was completed, the video technician uploaded the videotaped simulation onto a com-

puter, and the research assistant, who had experience in mentoring teams, projected specific segments from the video-recording onto a screen in the videotaped simulations room. The segments that were chosen included the focal points that highlighted the team's processes, ethical dilemmas and outcomes.

In order to create a supportive, nonjudgemental environment that is essential for making a simulation meeting effective, the research assistants phrased their comments and feedback in a supportive and non-judgemental way. The supportive atmosphere was reflected in the nurses' candid discussion of ethical events that they had experienced. As the simulations covered sensitive ethical issues, the discussions were prompted by a set of specific questions, like: 'Can you share with us one or more ethical dilemmas that arose in the team simulation?'; 'What do you think happened in reality?'

Data analysis

The videotaped simulations and discussions were all transcribed verbatim by two other research assistants and then processed as text. When transcribing the videotaped simulations and discussions, the research assistants used a code number for each participant to assure anonymity. Grounded theory was the methodology used because it emphasizes the emergence of ideas and themes from raw data (Taylor & Bogdan 1998). All the data were analysed independently by three people: the lead researcher and two research assistants who had not been present during data collection.

Data analysis followed a three-step process, as outlined by Strauss and Corbin (1998). The first step in the data analysis was open coding, in which the data were compared, conceptualized and categorized. Raw data were examined for similarities and differences, and initial conceptual categories were identified. More specifically, in the open coding stage of data analysis, similar ethical dilemmas were clustered into categories, for example, 'professional autonomy *vs.* obeying one's superior' (e.g. simulation 1) was based on several cases where nurses had to decide whether to act autonomously, based on their personal clinical knowledge, or to obey physicians' orders that have precedence over nurses' opinions according to the Israeli Ministry of Health.

The second step in the data analysis was axial coding, in which each ethical dilemma was placed along the axis of the core simulation. For example: (1) the ethical dilemma in simulation 1, which dealt with professional autonomy *vs.* obeying one's superior, was positioned

along the axis of the simulation benefit 'self-awareness', which refers to nurses' understanding of their strengths when dealing with physician authority; (2) the ethical dilemma in simulation 2, which dealt with collegial relationships *vs.* the duty to report, was placed along the axis of the simulation benefit 'relational transparency', which refers to openly sharing information and honest communication of nurses with their colleagues; (3) the ethical dilemma in simulation 3, which dealt with professional standards *vs.* caring for the patient, was placed along the axis of the simulation benefit 'balanced processing', which refers to nurses' willingness objectively to analyze relevant data and consider other views before making a decision; and (4) the ethical dilemma in simulation 4, which dealt with nurses' religious agenda *vs.* patient's religious beliefs, was placed along the axis of the simulation benefit 'internalized moral perspective', which refers to the internal moral standards that guide nurses.

The third step in the data analysis was selective coding, in which selected core categories of TBS's benefits were organized around a central explanatory concept. For example, in this study, where the central concept was 'toward authentic leadership in nursing', four core categories of TBS's benefits for authentic leadership were found to be related (self-awareness, relational transparency, balanced processing and internalized moral perspective).

To ensure accuracy of analysis, data were organized using the ATLAS.TI 5.0 software package that enables qualitative analysis of textual data (Muhr 2004). This software helps in methodically organizing and documenting themes within data and allows the user to collect text passages from one or more text documents (Crego *et al.* 2008).

Several steps were taken to establish the trustworthiness of the data collection and analysis procedures. First, the data were analysed by the lead researcher, who has extensive knowledge in organizational psychology, and by research assistants, who have extensive training in qualitative analysis. None of the researchers was a nurse practitioner, ensuring an outside perspective. Second, the data were authenticated through 'member checking', a process of returning the data analysis to participants in order to confirm accuracy. This was done in accordance with Lincoln and Guba (1985), who contend that a good researcher refines tentative results through participants' reactions, and this in effect puts the participants' perspectives at the centre of the study. Third, the lead researcher and the research assistants used a cross-checking procedure of independently-coded data and then held a meeting to

discuss preliminary findings and enhance the consistency of the analysis.

Findings

Table 1 presents the four core simulation benefits for authentic leadership with the common central explanatory concept 'toward authentic leadership in nursing'. The four core simulation benefits, which were derived from the quantitative analysis of the 50 simulation sessions, can be summarized as follows: (1) self-awareness (23 cases); (2) relational transparency (15 cases); (3) balanced processing (nine cases); and (4) internalized moral perspective (three cases).

Table 1 presents relevant excerpts from each simulation (see excerpts from team simulations column in Table 1).

Aside from four simulations, all the simulations revealed different team processes or different results from those that had actually occurred in practice (46 cases) (see examples from 'actual event' column in Table 1). The majority of the decision-making processes experienced by those participating in the simulations (35 cases) were characterized by a discussion among all parties concerned; in cases where nurses believed that their opinion was not given serious consideration during the discussions, they involved superiors in the decision-making process (e.g. simulation 1 in Table 1). In contrast, in a considerable number of actual cases involving ethical dilemmas (28 cases), decisions were made by the superiors only (head nurse/senior doctor) without involving employees who worked under their authority (e.g. simulation 4 in Table 1).

Based on the nurses' reported ethical events and their transcribed simulation meetings, the current data analysis revealed the following key findings regarding nurses' ethical dilemmas: (1) The main consideration in dealing with ethical dilemmas was caring, either for patients or other nurses (18 cases). (2) A significant number of ethical dilemmas dealt with the issue of whether or not to report misconduct of colleagues, i.e. nurses and doctors (14 cases). Other ethical dilemmas focused on the limits of autonomy: obeying superiors (nine cases), adhering to personal professional standards (six cases) and following personal religious beliefs (three cases).

Discussion

Nurses work in teams at the forefront of healthcare, and that means they must deal with numerous ethical dilemmas. However, they often lack the power to solve

Table 1
Benefits of TBS for authentic leadership: general outline

Dimension	Ethical events submitted by email	Excerpts from team simulations	Ethical dilemma	The actual event
Simulation 1: Self –awareness (based on 23 cases)	You are working on a gynaecological ward. The doctor has given you instructions to give an antibiotic to a patient. In your point of view, the patient is sensitive to one of the components of this antibiotic. The doctor does not agree to change the medication. What are you going to do?	<p>Nurse: 'Doctor, the patient is sensitive to this kind of antibiotic...'</p> <p>Doctor: 'This antibiotic does not belong to the group of antibiotics she is sensitive to.'</p> <p>Nurse: 'I don't accept your opinion... I'm not willing to give this medicine.'</p> <p>Doctor: 'It's not the first time we gave this antibiotic.... So please give it. If not, I will have to involve the professor.'</p> <p>Nurse: 'No problem... (the nurse phones). Professor Weiss, we need your advice. Dr. Amir has asked me to give an antibiotic to one of the patients. In her file it is written that she is sensitive to this group of antibiotics....'</p> <p>Professor: (asks to talk with Doctor Amir): '... This patient is sensitive to the penicillin component. Better be cautious, and give her an antibiotic from another group.'</p> <p>Doctor: 'O.K....'</p>	Professional autonomy vs. obeying one's superior.	The nurse refused to give the medication. Another nurse gave the medication.
Simulation 2: Relational transparency (based on 15 cases)	You are an experienced nurse in an emergency room. A new nurse in your ward asks you not to report the mistake she has made in medication distribution, because she is afraid that it will reduce her chance of getting a positive evaluation. No harm was suffered by the patient. During the shift, present are: an experienced nurse (yourself) and the new nurse. What are you going to do?	<p>Experienced nurse: 'I don't understand, you told me that you had already given Mr. Cohen his medication....'</p> <p>New nurse: '... He is in room number 3, right?'</p> <p>Experienced nurse: 'No, we have two 'Cohens' in the ward; you gave the medication to the wrong 'Cohen''</p> <p>New nurse: 'What a mistake !!!... It is only Advil. Nothing happened.... Almost 3 hours have past since I gave him the medication. Would you help me not to report this case? ... Reporting this case will reduce my chance of getting a good evaluation at the end of the year.'</p> <p>Experienced nurse: You should report this case. If you do not report it, and it is discovered, you will destroy your entire career.</p> <p>New nurse: 'O.K., Can you help me write it?'</p>	Collegial relationships vs. the duty to report.	No critical report was made, because no damage was caused to the patient.

Table 1
(Continued)

Dimension	Ethical events submitted by email	Excerpts from team simulations	Ethical dilemma	The actual event
Simulation 3: Balanced processing (based on nine cases)	You are a nurse in an orthopedics ward. You have discovered that a patient is being treated in more than one hospital, getting Voltaren injections without coordination between the hospitals, which means that she has received doses above the allowed limit. During the shift, present are: nurse (yourself), doctor, and head nurse. What are you going to do?	<p>Nurse: 'Doctor, this patient is being treated in more than one hospital, getting Voltaren injections, more than she is allowed....'</p> <p>Doctor: '....How has the system let this happen?'</p> <p>Head nurse: Let's meet with the district pharmacist. We should develop a routine practice for 'traveling patients'.</p> <p>Doctor: 'Good idea, meanwhile, please give the patient a blood test. We should prescribe her another medication.'</p>	Professional standards vs. caring for the patient.	The patient was sent for a blood test to have her medication adjusted.
Simulation 4: Internalized moral perspective (based on three cases)	You are the head nurse in an HMO in an ultra-orthodox community. A patient has asked a nurse to wear a head scarf because it is an ultra-orthodox clinic. She refuses. During the shift, present are: head nurse (yourself), nurse, and Ultra-orthodox patient. What are you going to do?	<p>Ultra-orthodox patient: '... This is an ultra-orthodox clinic, and it disturbs me that you don't respect our tradition'.</p> <p>Nurse: 'I'm traditional also... but I don't want to wear a kerchief on my head....'</p> <p>Head nurse: 'We respect your religious beliefs.... Another nurse, an ultra-orthodox nurse, will treat you'.</p> <p>Nurse: 'No one will force me to cover my hair'.</p>	Nurse's religious agenda vs. patient's religious beliefs.	The nurse was transferred to another clinic.

Note: Bold sentences show the connection between the simulation and the dimension it aims to present. All participants' names were changed to assure confidentiality.

these ethical dilemmas (Sorta-Bilajac *et al.* 2011). For that reason, it is important to identify the benefits of team-based simulations from an ethical perspective.

The study highlighted a four-dimension benefit model for using TBS around the central concept: 'toward authentic leadership in nursing': self-awareness, relational transparency, balanced processing; and internalized moral perspective. These findings can be transferred to any country where: (1) nurses' adherence to the professional code of ethics is lax; (2) nurses lack direct authority in most health matters, resulting in doctors making the decisions, and (3) nurses are subordinate to doctors.

The first benefit, 'self-awareness', focuses on nurses' understanding of their strengths and weaknesses. Training in a supportive environment may help nurses to change their strategy from defensiveness and uncertainty to self-confidence in their ethical decision-making. Traditionally, nurses have operated in compliance with doctor's orders. However, nurses have begun to reject the traditional paradigm of doctor dominance. As a result, nurses have acquired greater responsibility in decision-making, which has led to increased conflict between nurses and doctors when nurses try to take on more professional responsibilities (Tabak & Koprak 2007). TBS may help nurses better to understand their professional duties and the limits of their responsibilities, which in turn, may empower them to deal better with their ethical dilemmas.

The second benefit, 'relational transparency', focuses on nurses' honest and open communication with their colleagues (Jones 2007). Unethical behavior of co-workers often puts nurses in a very difficult situation. Colleagues' misconduct appears to be of concern to nurses, perhaps because they realize that once they take on senior positions, they will have to readjust their loyalties and priorities, and may even have to discipline nurses who have previously been their peers (Deshpande 2009).

The third benefit, 'balanced processing', 'focuses on nurses' willingness objectively to analyse and explore other opinions before making a decision. The findings indicate that caring for patients is one of the most important factors that nurses consider when facing ethical dilemmas, and it is that factor which usually determines their decision-making process (e.g. McGrath & Holewa 2006). Hence, an emphasis on a decision process that is based on discussing different opinions may lead to defining standards of care that may help nurses to guarantee the best possible care for their patients.

Finally, the fourth benefit, 'internalized moral perspective', focuses on internal moral standards. In the

Israeli context, religion and tradition play an important role on both the individual and the institutional level, whereby religious hospitals exist alongside state hospitals (Ammerman 2006). Ethical dilemmas are created as a result of the policy of the State of Israel to promote modern democratic values which may occasionally conflict with traditional values. TBS may prepare nurses to deal with such conflicts.

The supportive atmosphere at TBS meetings in the present study appeared to provide a safe and forgiving learning environment in which both the participants who role-played the simulations and those who discussed them could learn from role-players' errors without the risk of being destructive to others (Griffin 2003). In addition, nurses sometimes deal with mistakes through denial. In such cases, TBS could serve in breaking the code of silence surrounding mistakes, and may eventually reduce errors in nursing practice (Ziv *et al.* 2006).

The 'mistake-forgiving' environment at TBS meetings might explain the discrepancy found between ethical decision-making processes at TBS versus actual decisions made in practice. The atmosphere in which the actual decisions were made was often substantially different from the supportive atmosphere in which TBS were enacted. The stressful conditions accompanying real-life ethical dilemmas, time-constraints and uncertain conditions impair cognitive abilities affect decision-making processes, thus changing the outcomes (Werhane 1999, Christensen & Kohls 2003).

Possible factors that may hinder TBS effectiveness include: stress, which may trigger intense emotions; an intimidating environment; and apprehension of being judged by a mentor or peer (Savoldelli *et al.* 2005). In order to deal with these concerns, the current study designed a training context that offered a supportive environment to prevent unwanted reaction and to facilitate constructive criticism and personal growth.

The current findings highlighted the ethical dilemmas preoccupying nurses. Some of the ethical dilemmas are not unique to nurses; nevertheless, several aspects can be clearly understood within the framework of nursing. For example, ethical dilemmas are often rooted in a caring climate typified by positive collegial relations. Although healthcare systems often encourage friendships among nurses to cultivate a positive climate and increase hospital/HMO effectiveness (e.g. Tomey 2009), the present findings suggest that loyalty to colleagues may actually reduce healthcare effectiveness if nurses compromise professional standards to avoid harming their colleagues. Collegial relationships may also explain the sizeable number of ethical dilemmas

that dealt with the issue of obeying hospital/HMO rules or reporting misconduct of colleagues (doctors or nurses) when a clash occurs between colleagues' conduct and the rules of the healthcare system.

The variety of unresolved dilemmas that has emerged from the findings reinforces the claim of this study that nursing is a profession that is crying out for empowerment in ethical decision-making. This need may be fulfilled by encouraging nursing management to use TBS in nursing practice and help to develop authentic leadership among nurses.

Conclusions and recommendations

Nurses usually do not have enough time to discuss their authority and power-conflict that arise as a result of their ethical dilemmas. In addition, many nurses still act according to the traditional paradigm of doctor dominance and nurse deference. Thus, promoting nurses' authentic leadership through team simulations that are based on nurses' ethical experiences should be a priority for nursing management. Given the study findings about power and authority in teams, further research should be done to find out whether TBS helps to promote authentic leadership in other disciplines such as medicine, education, psychology and social work.

Implications for nursing management

The study findings emphasize the value of incorporating TBS into nursing practice, such as simulating a nurse-doctor power conflict and its resolutions. Integrating team simulation in nursing practice can be done through regular staff meetings, special meetings dedicated to team simulations and courses. All these activities will empower nurses to be more confident in their ethical decision-making, and in turn, may increase patients' safety and provide optimal treatment at health institutions.

In order to develop the future generation of authentic leaders in nursing, it may be beneficial to emphasize the four components of authentic leadership in TBS, specifically behaviours such as sharing information, being open and truthful in dealing with staff, soliciting feedback from staff, and highlighting the ethical standards behind decision processes and outcomes. This is likely to create a sense of empowerment as well as improved work outcomes.

Conflict of interest

No conflict of interest reported.

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Ethical approval

This study was approved by the Bar-Ilan University Review Board and by the ethics committees in the health institutions that were participating in the study.

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