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ORIGINAL

Nursing ethics in decision-making with palliative patients

Ética de enfermería en la toma de decisiones con el paciente paliativo

Roxanna Monserrate Toala Vera[1], Sandra Linares Giler[2]

[1]Universidad Técnica de Manabí, Licenciada en Enfermería del Hospital Oncológico "Dr. Julio Villacreses Colmont", Especialización en Enfermería Oncológica, Facultad de Posgrado. Portoviejo, Manabí.
[2]Universidad Técnica de Manabí, Facultad de Posgrado. Portoviejo, Ecuador.

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Corresponding Author: Roxanna Monserrate Toala Vera

ABSTRACT

Ethical decision-making by nursing professionals is defined as a sequential process consisting of professional responsibility and moral components, such as moral sensitivity. Objective: To assess ethical conduct in nursing decision-making for palliative patients in an Oncology Hospital. A study was carried out with an observational, descriptive, retrospective and cross-sectional approach. The population consisted of 52 nursing professionals. The technique used was the questionnaire, one to determine moral sensitivity in the CuSMCE-23 and the other to measure the ability to make ethical decisions Decision Making Questionnaire II. According to the sociodemographic characteristics of the professionals, those aged 31 to 40 years (42,31 %) showed a high degree of moral sensitivity. In the ability to make decisions, they reflected adaptation and clarity of criteria and objectives, but not for making a quick decision they considered to have little information. No significant differences were found between the degree of moral sensitivity and ethical decision-making. In conclusion, nursing staff have a high moral sensitivity for the care of palliative patients, however, they consider little information to make a quick decision, this being an essential aspect to guarantee a better quality of care in the face of ethical dilemmas.

Keywords: Palliative Care; Ethics; Nursing Ethics; Moral; Decision-Making.

RESUMEN

La toma de decisiones éticas de los profesionales de enfermería se define como un proceso secuencial que consta de responsabilidad profesional y componentes morales, como la sensibilidad moral. Objetivo: Valorar la conducta ética en la toma de decisiones de enfermería para el paciente paliativo en un Hospital Oncológico. Se realizó un estudio con enfoque observacional, descriptivo, retrospectivo y transversal. La población estuvo constituida por 52 profesionales de enfermería. La técnica utilizada fue el cuestionario, uno para determinar la sensibilidad moral el CuSMCE-23 y el otro para medir la capacidad en la toma de decisiones éticas Decision Making Questionnaire II. Según las características sociodemográficas de los profesionales los de 31 a 40 años (42,31 %) mostraron un alto grado de sensibilidad moral. En la capacidad para la toma de decisiones, reflejaron adaptación y claridad de criterios y objetivos, no así para la toma de una decisión rápida consideraron tener poca información. No se hallaron diferencias significativas entre el grado de sensibilidad moral y la toma de decisiones éticas. Como conclusión, el personal de enfermería presenta una alta sensibilidad moral para el cuidado de pacientes paliativos, sin embargo, consideran poca información para tomar una decisión rápida, siendo este un aspecto esencial para garantizar una mejor calidad de atención ante dilemas éticos.

Palabras clave: Cuidados Paliativos; Ética; Ética En Enfermería; Moral; Toma de Decisiones.

INTRODUCTION

Ethics is the behavior of a person or group of people guided by moral principles and values accepted as good within a society or community. In this sense, nursing ethics encompasses universal rules of conduct that provide a practical basis for identifying what types of actions, intentions, and motives are valued as correct.[1]

Nurses' knowledge of ethics and bioethics constitutes systematic principles of human behavior in the life and health sciences, which strive to uphold principles centered on helping, serving, and caring for patients with responsibility. Nursing care is based on bioethical principles aimed at promoting health, prevention, restoration, and the alleviation of suffering.[2]

In this context, ethical decision-making by nursing professionals is defined as a sequential process consisting of professional responsibility and moral components, such as moral sensitivity, judgment, motivation, and behavior. Professional responsibility is defined as taking responsibility for one's judgments and actions and therefore plays an essential role in nursing staff who take action in ethical decisions.[3]

Moral sensitivity, on the other hand, is the ability to become aware of patients' vulnerability and recognize ethical conflicts. Based on this, it is considered the first step in ethical decision-making. In addition, moral reasoning involves elucidating complex situations, finding optimal solutions, and making informed decisions. Moral agency is defined as the recognition, reflection, and ultimately the adoption of measures regarding one's responsibilities.[4]

Therefore, moral reasoning and moral agency contribute to turning the decision-making process from thought to practice. Meanwhile, moral practice is the ethical behavior that is the product of the ethical decision-making process of nursing staff. When nursing professionals complete this process, patients can experience a better quality of life by making the optimal decision at the end of life.[5]

Given the above, nursing staff play an essential role in improving the experience of patients in palliative care. These professionals meet patients' needs for optimal physical care, such as pain management, and promote a peaceful environment. In addition, they provide emotional and spiritual support to their patients and families, which requires ethical decision-making to ensure that patients receive dignified care.[6]

Previous studies have examined nursing ethics in decision-making with palliative patients. In a descriptive study conducted in Turkey by Baysal et al.[7] A study, which aimed to determine the levels of ethical decision-making among nurses with a population of 96 nursing professionals, found that the mean scores of nursing staff in principle-based thinking and practical considerations were above the moderate level. They concluded that, in order to improve the critical thinking and ethical decision-making skills of oncology nurses, it is important to identify the ethical dilemmas they face in clinical practice.

In Iran, Esmaelzadeh et al.[8] Conducted research to explain how ethical leaders strengthen ethical decision-making in their nursing teams. Data collected through in-depth and semi-structured interviews showed that ethical leaders strengthen ethical decision-making by promoting ethical commitment, developing an ethical atmosphere, and guiding ethical decision-making. In this regard, they concluded that the development of ethical decision-making in nursing can improve ethics-based nursing care.

Viccón and Ramos[9] conducted a study in Mexico to determine the degree of ethical behavior of nursing staff in their care of patients by applying an assessment scale. Their results were as follows: 4,3 % of nursing professionals obtained a high degree of ethical behavior, 45 % a normal level, and 52 % a low degree. Thus, the authors concluded that the ethics of nursing staff in general was low. Another study conducted in Mexico by Flores et al.[10] aimed to determine the level of moral development and ethical conduct of nursing students, with the following results: 73,3 % of respondents reported a high level of ethical conduct, and 4.6 % had a low level. In comparison, 67,9 % had a post-conventional level of moral development, and the remaining 30,1 % had a pre-conventional level. This concluded that they had characteristics typical of ethical care and adequate moral sensitivity.

In Ecuador, Cruz and Cunuhay[11] conducted descriptive research in Riobamba, where 50 % of nursing professionals are unaware of issues related to ethics. In addition, the application of the principles of non-maleficence (67 %) and justice (50 %) by nursing staff was evident. In this regard, they concluded that the majority of respondents correctly applied nursing ethics in decision-making.

In Cuenca, Morales et al.[12] Conducted a literature review to analyze the ethical behavior of nursing professionals in direct care. Their findings showed that nursing practice requires adherence to care protocols. Although international health organizations develop these protocols, they are also included in codes of ethics that view the practice as highly committed to the protection and respect of human dignity. Thus, it was concluded that knowledge of ethical principles allows nursing professionals to apply the recommended principles and values in the workplace to reduce suffering and promote patient recovery.

In Portoviejo, Briones et al.[13] Conducted a study to determine patients' perceptions of the application of bioethical principles and care by nursing students. The results showed that 70 % of the research participants applied the principle of autonomy, 50 % applied justice, 75 % applied the principle of beneficence, and 70 % applied non-maleficence. Based on this, it was concluded that adherence to ethics and morality in professional practice is essential for patient care and, therefore, increases the quality of care.

In particular, at the Dr. Julio Villacreses Colmont Oncology Hospital in Portoviejo, to date, no previous research has been found, nor has there been any study on ethics and decision-making among nursing staff providing palliative care. In this regard, it is considered relevant to have a study that allows for the evaluation of ethical behavior in decision-making by nursing staff in the care of palliative care patients.

This leads to the following scientific question: What is the ethical behavior in nursing decision-making for palliative patients in an oncology hospital in Ecuador?

Thus, this research has high social value due to the institutional mission based on providing humanized care through management and processes for the satisfaction of internal and external users, giving life expectancy to people with catastrophic diseases such as cancer, and, on the other hand, the human relevance given the situation of the nurse's actions, not only with technical knowledge and skills, but also with the development of the care process within an ethical framework, with the ability to work by the culture and traditions required by the nursing profession and, consequently, respect for the fundamental rights of palliative patients.

The overall objective of the study was to assess ethical behavior in nursing decision-making for palliative patients at the Dr. Julio Villacreses Colmont Oncology Hospital, with two specific objectives aimed at measuring the degree of moral sensitivity and capacity for ethical decision-making and, finally, determining significant differences between the degree of moral sensitivity and the capacity for ethical decision-making among nursing staff caring for these patients.

METHOD

This is an observational, descriptive, retrospective, and cross-sectional study conducted at the Dr. Julio Villacreses Colmont Oncology Hospital in Portoviejo, Manabí, Ecuador, during the last semester of 2024. The population consisted of 193 nursing professionals, and the sample was made up of 52 participants, selected through non-probabilistic convenience sampling under the inclusion criteria of working and caring for patients in palliative care, clinical, and hematology services; and the professionals agreed to participate in the research through the process and signing of the informed consent form. Those who provided incomplete data when filling out the questionnaires were excluded.

About the techniques and instruments used to collect the information, a data collection form was created relating to sociodemographic characteristics as part of the characterization of the sample with variables such as age, gender, educational level, religion, marital status, length of service at the institution, and length of service in the department. These variables were selected to explore possible associations between sociodemographic characteristics, moral sensitivity, and ethical decision-making capacity among nursing staff.

In turn, two questionnaires were used: one to determine the moral sensitivity of nursing staff, recently validated by Carmona and Montalvo[4] with a Cronbach's alpha of 0,77, and created initially and validated by Campillo.[14] This 23-item Moral Sensitivity in Nursing Care Questionnaire (CuSMCE-23) is divided into two dimensions: "values" (12 items) and "care responses" (11 items). Each item was evaluated on a Likert scale with six response options, where: 0 = total disagreement; 1 = considerable disagreement; 2 = slight disagreement; 3 = slight agreement; 4 = considerable agreement; and 5 = total agreement. Thus, the minimum score on the questionnaire is zero and the maximum is 115, with the values dimension ranging from 0 to 60 points and the care responses dimension ranging from 0 to 55 points. In this sense, values above 58 points are interpreted as a high degree of general moral sensitivity. In contrast, scores above 31 are interpreted as a high degree of moral sensitivity in the values dimension and scores above 28 in the care responses dimension.

On the other hand, to measure the ethical decision-making capacity of nursing professionals, the *Decision Making Questionnaire* II (DMQ-II) was used, designed and validated in 1982 by Professor Leon Mann of Flinders University[15] and subsequently validated in various studies.[16,17] This questionnaire consists of 34 statements with Likert-type response options with the following equivalence: 0 = Never/Rarely; 1 = Sometimes; 2 = Frequently; and 3 = Always/Almost always. Based on the above, the instrument was evaluated in three dimensions:

Stress in decision-making (items 1, 2, 5, 6, 8, 9, 10, 12, 16, 17, 21, 23, 24, 26, 27, 29, 30, and 31): measured with scores ranging from 18 to 36 points. A score higher than 36 indicated poor coping in decision-making, while scores lower than 18 indicated adaptation in decision-making.

Quick decision-making with uncertainty (items 3, 4, 7, 14, 18, and 20): measured with scores ranging from 6 to 12 points, where a score higher than 12 indicated a decision-making style that does not consider all available information for decision-making, while a score of less than 6 indicated a decision-making style that considers all available information for decision-making.

Determination and commitment in decision-making (items 11, 15, 19, 22, and 28): measured with scores

from 5 to 10, where a score greater than 10 indicated a lack of clarity in criteria and objectives with the use of escape and avoidance strategies in decision-making, while a score below 5 indicated clarity of criteria and objectives for decision-making.

Data collection was carried out through the Google Forms platform using a form where participants were presented with the informed consent form on the first page. Once they had read it, if they wished to participate, the questionnaire was opened for them to fill out. These were sent electronically to each participant, including the link to the questionnaire.

Data processing was carried out using Microsoft Excel version 2016 and SPSS version 25. To meet specific objectives 1 and 2, descriptive statistics were used in tables with frequencies and percentages. To achieve objective 3, which was to identify the association between moral sensitivity and the ethical decision-making ability of nursing staff caring for palliative patients, inferential statistics were used to identify statistically significant values.

Significant differences between moral sensitivity and ethical decision-making were analyzed using the t-test and analysis of variance (ANOVA). A two-tailed p-value of less than 0,05 was considered statistically significant.

The data obtained during the information gathering process were carefully stored and used only for research purposes, thus applying the ethical principle of confidentiality. These data are freely available and can be consulted at Mendeley Data.[18]

It should be noted that this research was approved by the Human Research Committee of the Technical University of Manabí (CEISH-UTM) with approval code CEISH-UTM-EXT_24-04-07_RMTV. To guarantee bioethical principles, the autonomy of the participants was respected by informing them about the objective of the research, its risks and benefits, and other details contained in the informed consent form, which they signed upon agreement.

RESULTS

The moral sensitivity expressed by nursing professionals according to their sociodemographic characteristics showed that 42,31 % are between 31 and 40 years of age and have a high level of moral sensitivity. 78,85 % are female, of whom 28,85 % reveal a low degree in the care responses dimension. On the other hand, of the 76,92 % of staff with a third level of education, 50,00 % reflect a high degree in the aforementioned dimension. Of those who profess a religion, 82,69 % have a high level of values, 46,15 % are single, and 30,77 % of this group indicate a high level of care responses. In addition, 63,46 % of staff have been working at the institution for 2 to 5 years, with 42,31 % showing a high level of care responses. Similarly, 51,92 % of staff with 1 to 5 years of service show a high level in this dimension.

Sociodemographic characteristics and decision-making capacity reveal that among professionals aged 31 to 40, 42,31 % report having little information to make decisions. Furthermore, among male respondents, 21,15 % exhibit adaptation to stress. Regarding educational level, 23,08 % of staff have a fourth-level education, with 19,23 % demonstrating clear criteria and objectives for decision-making in the determination and commitment dimension. In contrast, among the 17,31 % of respondents with no religion, only 5,77 % show moderate clarity in this dimension. On the other hand, 23,08 % of professionals are married, and 19,23 % of them consider that they have little information for decision-making. In addition, of the 26,92 % of people with more than 10 years of work experience in the institution, 15,38 % show adaptation to stress, while 3,85 % of respondents with more than 10 years of experience in the service show adaptation to stress.

The results of the statistical analysis showed that there are no statistically significant differences between the degree of general moral sensitivity expressed by nursing professionals and the different dimensions evaluated in terms of ethical decision-making capacity. These findings were obtained using the t-test for independent samples, which could not be fully calculated due to the lack of variability in the moral sensitivity data (standard deviation = 0), since all participants reported a high level in this variable, as shown in table 3.

However, there is a slight dispersion in decision-making, with the dimension “Quick decision with uncertainty” having the highest mean (2,2308), indicating that nursing staff are more likely to decide quickly under uncertainty compared to other dimensions such as stress or commitment.

The statistical probability using ANOVA explored the relationship between care responses (as an indicator of moral sensitivity) and the dimensions of ethical decision-making. The results did not find statistically significant differences between these variables (P = 0,225), reinforcing the conclusion that moral sensitivity is not associated with how nurses make ethical decisions. However, these findings can be explained by the homogeneity of the sample in terms of moral sensitivity, which limits the possibility of variations when related to other variables.

Table 1. Sociodemographic characteristics according to the degree of moral sensitivity of nursing professionals

Sociodemographic characteristics	Degree of moral sensitivity											
	Nursing values dimension				Care responses dimension				General moral sensitivity			
	Low		High		Low		High		Low		High	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Age												
22-30	0	0,00	13	25	5	9,62	8	15,38	0	0	13	25
From 31 to 40	0	0	22	42,31	8	15,38	14	26,92	0	0	22	42,31
Over 40	0	0	17	32,69	7	13,46	10	19,23	0	0	17	32,69
Gender												
Female	0	0,00	41	78,85	15	28,85	26	50	0	0	41	78,85
Men	0	0	11	21,15	5	9,62	6	11,54	0	0	11	21,15
Educational level												
Third level	0	0	40	76,9	14	26,92	26	50	0	0	40	76,92
Fourth level	0	0	12	23,08	6	11,54	6	11,54	0	0	12	23,08
Doctorate	0	0	0	0	0	0	0	0	0	0	0	0
Religion												
Yes	0	0	43	82,69	18	34,62	25	48,08	0	0	43	82,69
No	0	0	9	17,31	2	3,85	7	13,46	0	0	9	17,31
Marital status												
Married	0	0	12	23,08	7	13,46	5	9,62	0	0	12	23,08
Divorced	0	0	7	13,46	2	3,85	5	9,62	0	0	7	13,46
Single	0	0,00	24	46,15	8	15,38	16	30,77	0	0	24	46,15
Common-law marriage	0	0	9	17,3	3	5,77	6	11,54	0	0	9	17,31
Time working at the institution												
2 to 5 years	0	0	33	63,4	11	21,15	22	42,31	0	0	33	63,46
6 to 10 years	0	0	5	9,62	1	1,92	4	7,69	0	0	5	9,62
More than 10 years	0	0	14	26,92	8	15,38	6	11,54	0	0	14	26,92
Time working in the service												
1 year to 5 years	0	0	45	86,54	18	34,62	27	51,92	0	0	45	86,54
6 to 10 years	0	0	3	5,77	1	1,92	2	3,85	0	0	3	5,77
More than 10 years	0	0	4	7,69	1	1,92	3	5,77	0	0	4	7

Note: N = sample elements; % = percentage of the sample

Table 2. Sociodemographic characteristics and ethical decision-making capacity of nursing professionals

Sociodemographic characteristics	Decision-making																			
	Stress						Quick decision-making with uncertainty						Determination and commitment							
	*Adapted		®Reg		≈Afr		û With		¥With little		^No with		©Clear		×Med clear		£Some clarity		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Age																				
22-30	10	19,23	2	3,85	1	1,92	0	0	10	19,23	3	5,77	11	21,15	2	3,85	0	0	13	25
From 31-40	14	26,92	8	15,38	0	0	0	0	19	36,54	3	5,77	16	30,77	6	11,54	0	0	22	42,31
Over 40	9	17	6	11,54	2	3,85	2	3,85	7	13,46	8	15,38	9	17,31	5	9,62	3	5,77	17	32,69
Gender																				
Female	23	44,23	16	30,77	2	3,85	2	3,85	27	51,92	12	23,08	26	50,00	12	23,08	3	5,77	41	78,85
Male	10	19,23	0	0	1	1,92	0	0	9	17,31	2	3,85	10	19,23	1	1,92	0	0,00	11	21,15
Educational level																				
Third level	23	44,2	14	26,92	3	5,77	1	1,92	28	53,85	11	21,15	26	50,00	11	21,15	0	0	40	76,92
Fourth level	10	19,23	2	3,85	0	0	1	1,92	8	15,38	3	5,77	10	19,23	2	3,85	3	5,77	12	23,08
Doctorate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Religion																				
Yes	29	55,77	12	23,08	2	3,85	1	1,92	31	59,62	11	21,15	31	59,62	10	19,23	2	3,85	43	82,69
No	4	7,69	4	7,69	1	1,92	1	1,92	5	9,62	3	5,77	5	9,62	3	5,77	1	1,92	9	17,31
Marital status																				
Married	6	11,54	6	11,54	0	0	0	0	10	19,23	2	3,85	8	15,38	3	5,77	1	1,92	12	23,08
Divorced	3	5,77	3	5,77	1	1,92	0	0,00	3	5,77	4	7,69	4	7,69	2	3,85	1	1,92	7	13,46
Single	17	32,69	5	9,62	2	3,85	2	3,85	16	30,77	6	11,54	17	32,69	6	11,54	1	1,92	24	46,15
Common-law marriage	7	13,46	2	3,85	0	0	0	0	7	13,46	2	3,85	7	13,46	2	3,85	0	0	9	17,31
Time working at the institution																				
2 to 5 years	23	44,23	9	17,3	1	1,92	0	0	25	48,08	8	15,38	24	46,15	9	17,31	0	0	33	63,46
6 to 10 years	2	3,85	2	3,85	1	1,92	1	1,92	3	5,77	1	1,92	4	7,69	0	0	1	1,92	5	9,62
More than 10 years	8	15,38	5	9,62	1	1,92	1	1,92	8	15,38	5	9,62	8	15,38	4	7,69	2	3,85	14	26,92
Time working in the service																				
1 year to 5 years	30	57,69	2	3,85	13	25	1	1,92	33	63,46	11	21,15	33	63,46	11	21,15	1	1,92	45	86,54
6 to 10 years	1	1,92	1	1,92	1	1,92	1	1,92	0	0	2	3,85	1	1,92	0	0	2	3,85	3	5,77
More than 10 years	2	3,85	0	0	2	3,85	0	0,00	3	5,77	1	1,92	2	3,85	2	3,85	0	0	4	7

Note: *Adap = adaptation; ®Reg = regular; ≈Afr = poor coping; ûCon = considers all available information; ¥ with little = considers little information; ^No con = does not consider all available information; ©Clar = clarity of criteria and objectives for decision-making; × Med clar = medium clarity; £Poca clar = little clarity of criteria and objectives

Table 3. T-test between moral sensitivity and ethical decision-making ability among nursing staff

	No.	Mean	Standard deviation	Standard error of the mean
Degree of general moral sensitivity	52	1	0,00000[a]	0,0000
Stress in decision-making	52	1,4231	0,60541	0,08395
Quick decision with uncertainty	52	2,2308	0,50934	0,07063
Determination and commitment in decision-making	52	1,3654	0,59504	0,08252

Note: a. T cannot be calculated because the standard deviation is 0.

Table 4. ANOVA results

Model		Sum of squares	gl	Mean square	F	Sig.
1	Regression	1,058	3	0,353	1,505	0,225[b]
	Residual	11,249	48	0,234		
	Total	12,308	5			

Note: a. Dependent variable: Care responses; b. Predictor variables: (Constant), Determination and commitment in decision-making, Quick decision with uncertainty, Stress in decision-making

DISCUSSION

The results obtained regarding the sociodemographic characteristics of nursing professionals who care for palliative patients, as measured by moral sensitivity, showed a predominance of people aged 31 to 40 (42 %), who also had the highest overall moral sensitivity. However, most of the female respondents (79 %) showed a low degree of moral sensitivity in the care responses dimension (29 %) compared to men. In comparison, most of the participants with a third-level education (77 %) showed a high level in the care responses dimension.

Similarly, Zeru et al.[19] It was noted that most participants (71,9 %) were women aged 31 to 40 (46,4 %) with a tertiary level of education (57,9 %). Similarly, in the study by Carmona and Montalvo[20], the overall moral sensitivity of nurses toward terminally ill patients was high at 80 %, of whom 89,8 % of respondents were women, aged 31 to 40 years (41,5 %), and 79,7 % had only undergraduate training. Additionally, these authors mention that the category of care responses reached 70,4 %, which is similar to the present study.

On the contrary, other studies report negative results regarding the moral sensitivity of nursing professionals. Afrasiabifar et al.[21] indicated that only 11,6 % had a high level of moral sensitivity, with an average age of 32, and only 5,6 % of staff had a fourth level of education. In this regard, Amiri et al.[22] mentioned that 32,8 % of nursing staff had high moral sensitivity, and 53,5 % were men with an average age of 31 years. This contrasts with Darzi et al.[23], where the majority had a moderate level of moral sensitivity (89,1 %).

Another finding of the current study reported scores that showed decision-making ability according to sociodemographic characteristics, reflecting a minority of respondents without religion (17 %), of whom 6 % showed moderate clarity in decision-making about the dimension of determination and commitment. In addition, it was found that most married professionals (24 %) consider little information when making decisions (19 %) and that staff with more than 10 years of work experience in the institution (27 %) show better adaptation to stress (15 %), while half of those with more than 10 years of experience in the service (8 %) show adaptation to stress in decision-making (4 %).

These results were in line with those of Rego et al.[24] In this context, most participants (58,9 %) demonstrated adaptation in decision-making, while only 1,9 % did not profess any religion. This is also similar to the findings of Arends et al.[25] Nursing staff reported focusing exclusively on the patient when making decisions, without considering other information (62 %), with a minority being married (30 %) and having more than 15 years of work experience (12 %).

In contrast, the qualitative study by Bos-Van et al.[26] showed that nursing professionals consider the transfer of information between colleagues and other health professionals to be essential for decision-making, and 3 % of them reported between 10 and 14 years of work experience as palliative care nurses.

Finally, this study found no significant difference between the moral sensitivity and ethical decision-making ability of nursing staff caring for palliative patients. However, published studies have reported a correlation between the variables mentioned. In this regard, Luo et al.[27] positively correlated moral sensitivity with ethical decision-making ($p < 0,01$). Similarly, in the research conducted by Lim et al.[28], moral sensitivity was an influential factor in the ethical decision-making of nursing staff ($p < 0,001$).

This study has some limitations. First, the sample selected from a single hospital complicates the application

and generalization of the results to all demographic groups. Second, since all findings are based on self-perception questionnaires, they may not fully represent the actual phenomenon. Therefore, when analyzing these findings, subjectivity must be taken into account, and further research with a larger number of participants is recommended to examine nursing ethics in decision-making and consider the inclusion of cancer patients and their families, who are the recipients of care from these professionals.

CONCLUSIONS

The sociodemographic characteristics of the nursing professionals showed that the majority are between 31 and 40 years old, female, with a tertiary education, religious, single, with 2 to 5 years of work experience at the institution, and 1 to 5 years of work experience in the service.

In terms of moral sensitivity to the care of palliative patients, they generally show a high degree. In the values dimension, all participants scored high; however, the results obtained in the care responses dimension showed low scores. In terms of decision-making ability, the staff demonstrated adaptability and clarity in their criteria and objectives for decision-making. However, the professionals considered that they had little information to make quick decisions, which is an essential aspect to ensure that patients receive better quality care when faced with ethical dilemmas.

The differences between the moral sensitivity and ethical decision-making capacity of nursing staff showed that high moral sensitivity does not influence the ethical decision-making process. However, because moral sensitivity is an important attribute of nursing professionals in determining and resolving the ethical challenges inherent in palliative care, the findings presented could make a significant contribution to the daily practice of nursing staff who are influenced by their moral and ethical values.

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AUTHORSHIP CONTRIBUTION

Conceptualization: Roxanna Monserrate Toala Vera.
Data curation: Roxanna Monserrate Toala Vera.
Formal analysis: Roxanna Monserrate Toala Vera.
Research: Roxanna Monserrate Toala Vera.
Methodology: Roxanna Monserrate Toala Vera.
Project management: Roxanna Monserrate Toala Vera.
Resources: Roxanna Monserrate Toala Vera.
Software: Roxanna Monserrate Toala Vera.
Supervision: Sandra Linares Giler.
Validation: Roxanna Monserrate Toala Vera and Sandra Linares Giler.
Visualization: Roxanna Monserrate Toala Vera.
Writing – original draft: Roxanna Monserrate Toala Vera.
Writing – correction and editing: Roxanna Monserrate Toala Vera and Sandra Linares Giler.