

Nudging in Nursing

Abstract

Nudging is a concept in behavioural science, political theory and economics that proposes indirect suggestions to try to achieve non-forced compliance and to influence the decision-making and behaviour of groups and individuals. Researchers in medical ethics are currently discussing whether nudging is ethically permissible in health care. In this article, we look into current knowledge about how different decisions (rational and pre-rational decisions, major and minor decisions) are made and how this decision-making process pertains to patients. We view this knowledge in light of the nursing project and the ongoing debate regarding the ethical legitimacy of nudging in health care.

We argue that it is insufficient to discuss nudging in nursing and healthcare in light of free will and patient autonomy alone. Sometimes, nurses must take charge and exhibit leadership in the nurse-patient relationship. From the perspective of nursing as leadership, nudging becomes a useful tool for directing and guiding patients towards the shared goals of health, recovery and independence and away from suffering. The use of nudging in nursing to influence patients' decisions and actions must be in alignment with the nursing project and in accordance with patients' own values and goals.

Keywords

Nudging, patient autonomy, paternalism, nursing, leadership

Introduction

On a day-to-day basis, healthcare personnel encounter ethical dilemmas between respecting the patients' right to autonomy and the obligation to act according to the principles of beneficence and non-maleficence. An asymmetrical division of power, with healthcare personnel having more power than patients, also marks the relationship between healthcare personnel and patients.¹⁻³ In these situations, the patients are protected by the principle of the patients' right to autonomy and informed consent. However, in order to provide health care, health care professionals are assumed/expected, in some situations, to exhibit a mild, soft or liberal paternalism.^{1,2,4,5} Execution of power will frequently entail a violation of patients' dignity. Dignity is violated when, for instance, a person's autonomy is not respected or fostered. Nudging and 'choice architecture' is, according to Thaler and Sunstein,⁶ a very mild/soft form of paternalism that safeguards the freedom of others because it is so easy to resist. Researchers in medical ethics are currently discussing whether nudging is morally permissible or not in the healthcare context. We have found no previous studies on nudging in the nursing context. We do, however, believe that many nurses apply nudging to patients in their everyday practice, despite not knowing of the concept and theory behind it.

In this article, we set out to show that nudging, in some situations, may be a legitimate tool of influence in nursing that also safeguards patients' dignity. We will accomplish this aim by exploring what decision theory can tell us about decisions (rational and pre-rational decisions, and major and minor decisions). We will look into patients' capacity to make rational decisions, when in need of nursing care, and relate this capacity to nurses' objectives and responsibilities, as defined by the International Council of Nurses (ICN). Then, we will look at the ongoing debate on the ethical legitimacy of the use of nudging in health care. We argue that nurses must sometimes take charge and exhibit leadership in the nurse-patient relationship, and that nudging patients is ethically permissible and desirable in this context as a way of influencing patients regarding some decisions.

There are various ways to define nursing. For this discussion, we will use the ICN⁷ definition of the nursing function. This definition states that:

'The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full or partial independence as rapidly as possible'.^{7,8}

When we inform, educate and motivate patients about the necessity to undertake healthy activities, we address the patient's knowledge and rational judgement. When we offer physical support and carry out actions for the patients, we address the patient's lack of strength. We believe that nudging may be a tool used by nurses addressing the patients' lack of will.

In this discussion, we also emphasize that nursing aims to help patients gain independence. In other words, the intent of nursing actions is concerned with enhancing the patient's independence and autonomy. In this approach, lies the important recognition that the patient, in the moment when he needs nursing, is in a state of enhanced dependency and vulnerability.

Background

Many decisions we make as humans are strikingly irrational. We recognize this when we try to resist temptations, when we fail to exert willpower, and, in some situations, when we provide care for people who are ill or experiencing a crisis. Studies on what influences people's assessments have revealed two separate thought processes linked to choices and decision-making, referred to as System 1 and System 2.⁹ System 2 refers to a rational process, during which people think slowly and carefully evaluate available information to reach a rational decision. We use this thought system when we make decisions we perceive as major and important. These are conscious and rational decisions. System 1, on the other hand, consists of a quick, instinctive pre-rational process. We use this process when we make less important everyday decisions, the minor decisions. The slow, rational thought process requires a considerable amount of energy.^{9,10} The quick pre-rational thought process is unconscious and spontaneous and requires little energy. This process uses heuristics, emotions and routines when assessments are made and often sets up barriers to our rational decision-making.⁹ The use of the rational system 2 to override the pre-rational system 1 impulses requires use of will-power or self-control. In psychology, lack of will-power (ego-depletion) describes a situation where one lacks the mental energy to use system 2 to override system 1 decisions.¹⁰⁻¹² In philosophy, on the other hand, free will and autonomy are fundamental moral concepts,¹³ often seen as the foundation of human dignity.

Choice architecture and nudging

Thaler and Sunstein⁶ suggested that we should apply knowledge pertaining to how people make decisions using the quick instinctive and pre-rational thought process to condition decision-making situations and gently direct people's choices and actions in a desired direction. This approach would be useful for health-promoting strategies at a national level. Thaler and Sunstein called this conditioning of choice-making situations 'choice architecture' (designing and structuring of choice-making situations) or 'nudging' (referring to the act of giving people a friendly nudge in the right direction). Moreover, they claim that this 'nudge' is so mild that it permits people who want to resist the nudge to do so easily.⁶ The person's freedom is thereby, they argue, still respected.⁶ A typical example of nudging is to place fruits and vegetables easily accessible and deliciously arranged. This influences customers to eat more fruit and vegetables, while still preserving their freedom to choose unhealthy food. To forbid or restrain the accessibility of unhealthy food, or to ask those who choose unhealthy food to change their mind and choose something healthier, is not nudging. Neither are incentives, regulations and arguments.⁶ Another example of nudging is the sequence one presents information about different options to the patients. Whether healthcare professionals mention the benefits of

a treatment, or the inconveniences or side effects first, will affect how the patient perceives the given options. In this case, the information about benefits and side effects per se, is not nudging. The nudging is in the deliberate application of knowledge about how the sequencing of the information affects the perception of the information.

Autonomy and paternalism

The right to autonomy, self-governance and informed consent are among the core values in our society, in medical ethics and in nursing ethics.¹⁴ A person acts autonomously when he acts of his own free will and without controlling influences. Free will can be influenced through coercion, persuasion or manipulation.¹⁵ Disregard of a person's self-determination or autonomy, with a view to benefiting or protecting the person whose autonomy is disregarded, is called paternalism.¹⁴ To act against the person's explicit wishes (informed, voluntarily and autonomous) is considered strong or hard paternalism. If the patient's capacity for autonomy is sufficiently compromised, we consider the acting without consent to be weak or soft paternalism, and morally permissible.^{13,14} Thaler and Sunstein⁶ claim that nudging belongs to the category of soft paternalism, as nudging is easy to resist. This means that the concept of soft paternalism is used to describe two different dimensions pertaining to the paternalistic actions. First, the traditional view dividing paternalism into hard and soft paternalism depends on the person's capacity for autonomy, whereas the second view dividing paternalism into soft and hard paternalism depends on how easy the influence is to resist. A third dimension pertaining to nudging and paternalism is that nudging occurs before the person has formed an explicit wish. One may therefore also argue that one is not acting contrary to the person's wishes; rather, one is leading the person before the person has formed his/her own assessment of the situation. According to Beauchamp and Childress,¹⁵ soft paternalism reflects the intended beneficiary's conception of his or her best interests and values, even if (when) the intended beneficiary fails to pursue them. Liberalist philosophers argue that soft paternalism is still manipulation, as we impose our view on the other person.¹⁶

Disregarding a person's autonomy and explicit wishes through the use of coercion is a violation of the person's dignity. Persuasion using rational arguments, however, does not violate the person's autonomous choice and dignity in the same manner. Manipulation using lies, exaggerations or withholding information as well as manipulation that makes us act contrary to our own wishes and values is perceived as violation of a person's dignity.¹⁴ Manipulation that helps us attend to our own values and interests is defined as soft paternalism.^{2,4,5,13} In accordance with these researchers and Beauchamp and Childress,¹⁴ we believe that this latter form of manipulation might not violate people's dignity. This influence, may instead be seen as removing barriers and obstacles, and facilitating actions the person being influenced wants to perform¹⁷. Thus the influence contributes to preservation of the person's dignity instead of violating it.

In nursing, there has been a tradition of both advocating for patients' right to autonomy¹³ and defending the necessity of mild or soft paternalism in some situations.^{2,13} In some cases, this position gives rise to ethical dilemmas such as when, for instance, a nursing home patient continually refuses to have a morning toilet. On the condition that

this patient has the capacity to make an autonomous choice concerning having a morning toilet, manipulation, coercion, or persuasion to make him have it will compromise the patient's autonomy. At the same time, respecting the patient's autonomous choice of not having a morning toilet for several days or weeks may have the patient suffer more harm and pose a greater threat to the patient's dignity in the end. Caring for patients when there are conflicting normative claims, such as between respecting autonomy and preventing harm (or doing good), accentuates awareness of contextual circumstances as well as the underlying emotional and cognitive aspects. In such cases, a mild or soft form of paternalism through persuasion, by appealing to rational arguments (e.g., 'Your skin problem is getting worse') or by appealing to emotions (e.g., 'Your wife is coming to see you, I am sure she will be happy to see you') may be preferable. Notably, as Beauchamp and Childress¹⁴ write: 'In health care, the problem is to distinguish between emotional responses from cognitive responses and to determine which are likely to be evoked. Disclosures or approaches that might rationally persuade one patient might overwhelm another whose fear or panic undercuts reason' (p. 139). In these situations, the use of nudging strategies may prevent the patient from refusing the morning toilet and thus prevent the need for persuasion and pressure on the patient to change his mind.

Saghai¹⁷ divides situations, where a person attempts to influence on another person, into three different categories, related to whether preferences, goals and values of the influencer and the person being influenced are aligned. First there are situations with dissonance between the influencer's preferences, and those of the person being influenced. Second there are situations with harmony between the influencer's preferences and those of the influenced person. In the third category the person who is being influenced, has no preference. We argue that nudging is a legitimate tool to influence on patients' decisions in nursing situations where there is harmony between the preferences of the patient and the nurse, and in situations where the patient has no preference. The minor decisions we refer to later in this article, belong to these two categories. We do not argue that nurses should nudge in situations where there is dissonance in the preferences, goals and values of nurse and patient, as this may be in conflict with the patients' right to autonomy. Though Saghai,¹⁷ claims that nudging is easy to resist, in situations with conflicting goals and values, as being nudged in the opposite direction of one's goals and values, will create a cognitive dissonance, activating the person's attention. This he says, will make the person able to resist the nudge even though nudging influences pre-rational and shallow assessments.¹⁶

The ethical discussion pertaining to nudging in healthcare

Research on nudging in the health care context is currently mainly restricted to ethical discussions about whether nudging is permissible or if nudging violates patient autonomy and the right to informed consent. Ploug and Holm¹⁸ and Holm and Ploug¹⁹ hold the libertarian stance and state that nudging is in conflict with the principle of personal autonomy and informed consent. The authors claim that nudging breaks with the patient's autonomous choices because the patient is manipulated into what healthcare personnel find is in the patient's best interests, without regard for what the patient himself/herself may want. Hence, they argue that domains where informed consent is requested are

incompatible with nudging. Notably, they acknowledge that there are domains where informed consent is not requested, where nudging is permissible, and a grey domain where informed consent may or may not apply. Still, according to Ploug and Holm,¹⁸ nudging has no place in the clinical encounter between health care personnel and patients, because these situations belong to the domain that requires informed consent.

Cohen,^{5,20} on the other hand, claims that nudging combines the principle of benevolence and respect for the person's autonomy in so beneficial a way that nudging strategies should be part of health personnel's inventory of tools, including in situations that involve informed consent. He also declares that nudging may, in some situations, enhance patients' autonomy by countering the influence of cognitive biases on the patient's decisions.^{5,20}

Others argue that nudging may be ethically defensible in some instances because people are not exclusively rational and emphasize that when we make irrational choices, we do not act in conformity with our own objectives and values. Furthermore, these researchers think that any situation involving a choice also involves an influence in one direction or another. They claim that it would be better if the influence is well thought out and linked with what is best for the patient and with what we suppose the patient would have chosen, if the patient had made a rational choice.^{4,20-23} Munoz et al.²³ also claim that patients both want and expect healthcare personnel to exercise a certain amount of authority because healthcare personnel possess expertise and know what is best.

The libertarian position conceives nudging as manipulation and a violation of people's autonomy. If, on the other hand, one approves of paternalism, then nudging patients may be defensible.¹⁶ Our worry is that too narrow a focus on patient autonomy may become a way of disclaiming responsibility for the patients and thereby indirectly cause the patient harm instead of protecting the patient's dignity. Even though the patient has the right to autonomy and informed consent, patients should not be forced to make autonomous decisions when they do not want to do so or when they do not have the necessary capacity to make autonomous decisions.

Different decisions, major and minor decisions

Decision theory depicts how we make decisions in at least two different ways, corresponding to different levels of decisions.⁹ It is hence purposeful to divide decisions into two levels when discussing whether nudging may be permissible or not in nursing: major decisions and minor decisions.

Major decisions pertain to our values and goals, are made only once or a few times and are likely to have severe consequences on our life. These decisions should be based on rational assessment of available information, and in healthcare, according to guidelines pertaining to informed consent. Decisions concerning, for example, whether to undergo knee replacement surgery or whether to enrol in a screening programme for breast cancer, are major decisions in this respect. It is beyond the scope of this article to discuss whether nudging might be permissible in these situations.

Our concern lies with the minor decisions, i.e., the small everyday decisions that affect the actions we must take if we are to live according to our values and achieve our goals (often determined by major decisions). Elsewhere, one of us has labelled any such activity taking place in the encounter between a nurse and a patient, aimed at certain shared goals, as nursing projects.²⁴ Decisions involved in nursing projects are likely to concern the performance of 'activities contributing to health or recovery or to dignified death that they (the patients) would perform unaided if they had the necessary strength, will, or knowledge'.⁷ In other words, these activities are related to patients' basic needs and implementation of preventive measures. For example, they might include decisions concerning when and how much to eat and drink or when and how to get out of bed, have a wound dressed, or take the prescribed medication. These decisions are often pre-rational (system 1) and, thus, often not built on rational decision-making (system 2); rather, they are built on heuristics, cognitive biases, emotions and routines.⁹ These minor decisions primarily belong to situations where the goals and values of nurses and patients are aligned and/or situations where the patient has no preference. Therefore, these decisions belong to the domain where explicit informed consent is not requested, even though they occur in the clinical encounter between healthcare personnel and patients.

Ploug and Holm¹⁸ take the libertarian stand that nudging in healthcare is in conflict with the principle of autonomy and informed consent. They do, however, acknowledge that there are domains where informed consent is not required, where nudging is permissible. They claim that these situations are not found in encounters between patients and healthcare personnel, as these encounters belong to the domain of informed consent. We disagree with Ploug and Holm, as we find that nursing pertains to all three domains: domains where informed consent is requested, domains where informed consent is not requested, and the grey area, where informed consent may or may not be requested. These three domains coincide with different levels of decisions: major and minor decisions. It is more important for major decisions to be informed, rational and autonomous than it is for minor decisions. Hence, nudging may be impermissible in situations with major decisions, permissible in situations with more minor decisions, and even required in situations concerning very small decisions (for instance, which arm or leg to move first when getting out of bed or brushing teeth).

The ability to make rational decisions; patients' willpower

Every day, we (people) have to make an abundance of decisions. Wansink and Sobal²⁵ found that we make over 200 decisions simply pertaining to food on a daily basis. Additionally, psychologists describe how the plethora of choices we need to make every day leads people to exhaustion and depression.^{26,27} Too many choices may lead to a situation in which one lacks the mental energy or willpower to make rational decisions.¹⁰⁻¹² In nursing, it might very well be the case that too many decisions exhaust patients, instead of safeguarding their autonomy and dignity. Being a patient often implies being ill or sick and suffering a lack of energy and strength. These circumstances make it more difficult and exhausting for patients to make rational decisions. Again, the same situation makes patients more prone to rely on pre-rational assessments and decisions based on heuristics, cognitive biases, emotions and routines, when in need of rational decisions (system 2 should override system 1).⁹ We recognize this same situation when we

experience decreased willpower from being tired, hungry or under pressure, and when, as nurses, we care for patients struggling to make choices. Virginia Henderson recognized this phenomenon in patients, and thus we find the ICN nursing definition states that patients may either lack strength, will or knowledge when they need the assistance of a nurse. We also recognize the lack of willpower preventing patients from making rational decisions in patients who are non-compliant or non-adherent to a prescribed therapeutic regimen. Thus, leaving many minor decisions to patients, who already lack mental energy (will), may contribute to enhancing the patients' ego-depletion even further. Patients might be quite worn out from constant questions about what the patient wants, a well-known phenomenon in nursing, first described by Florence Nightingale in her notes on nursing.²⁸ Leaving too many decisions or the wrong decisions to the patient himself, thus, may contribute to what Martinsen² calls 'sin of omission', or malpractice and negligence.

This sin of omission may result from too much emphasis on liberal individualistic morality, according to which non-interference and ensuring freedom of choice should be practised.¹⁶ As Held,²⁹ in a critique of liberal individualism, states, '[Care ethics] often call on us to *take* responsibility, while liberal individualist morality focuses on how we should leave each other alone' (pp. 14-15). Of note, taking responsibility does not equal taking responsibility *from* patients who are able to hold the responsibility but, rather, a way of relieving patients from the responsibility they cannot hold. Care ethics typically emphasises a conception of persons not as self-sufficient and independent, but as relational and dependent.²⁹ According to care ethics, the agent is responsible with regard to particular persons in his and her situatedness.³⁰ From this, we believe that nudging can be situated within a care ethical approach. Importantly however, we will not argue for a strong paternalistic conception of nursing care. At the same time, we must acknowledge that many patients are in a state where they are less capable of making decisions and maintaining responsibility. Nurses are responsible for helping patients enhance or regain their independence in these situations.

In line with Martinsen,² we argue that this perspective means that the use of soft paternalism is not only legitimate but might even be required in some situations. In these situations, the nurse must use professional and ethical knowledge to make discretionary assessments on behalf of the patient and sometimes become a surrogate decision maker^{14,15} for the patient, even though there may be violation of the patient's autonomy to some extent. Furthermore, we claim that paternalism to override patients' own assessments, decisions and will, after they have been made explicit, is more violating of patients' dignity than influencing patients' assessment of situations through nudging, before the patients have made up their mind. Thus, obviously, there is a normative difference between the statement 'You have made up your mind, but I am not going to respect it' and the statement 'Please consider my advice before you make up your mind'. At the same time, very often in nursing care, decisions concerning a patient's welfare are not made only once, but must be repeated by the patient. Decisions concerning mobilization after surgery, taking a prescribed medication, and changing to a healthier life style are all instances of decisions that are usually repeated several times during a day or in the long term. In nursing, influencing choices/nudging, in such situations may be based on awareness of the different factors influencing the patient's decision, and

thereby, respecting his autonomy to a greater extent, as the nurse enables him to choose and act in accordance with his own major goals and values.

Leading the patient towards health and recovery

As we have seen, nursing occurs in situations in which patients must make choices at different levels and with different degrees of severity. To surrender patients to their immediate impulses (pre-rational decisions) in order to protect patients' autonomy and free will is misguided. To insist on autonomy and informed consent in all situations and regarding all minor decisions would be a disclaiming of responsibility, of the nurse, regarding dependent and vulnerable patients. This situation would be one of negligence and a sin of omission. In these circumstances, the nurse must take responsibility and lead the patients towards health and recovery, and away from suffering.

Our conclusion is, that situations such as those mentioned above, belong to the domain in which informed consent is not requested and nudging is permissible even though they occur in an encounter between healthcare personnel and patients. As such, nudging is not covert manipulation; rather, it is a legitimate tool that may facilitate actions and ensure movement and direction towards a common goal, the patient's recovery, health and independence. We therefore propose that these situations are understood in light of the leadership concept rather than from the perspective of autonomy and free will, as these are situations where the nurse is responsible for leading the patient towards a set of shared goals. According to Stroud,³¹ a goal is something one intends to bring about, something towards which one directs one's agency. In nursing, the goals in question relate to the basic areas of nurses' responsibilities and are brought about in nursing projects.²⁴

Nursing as leadership

Leadership is a phenomenon and process that emerges in the context of interaction and entails giving the human substance movement and direction towards a common goal.^{32,33} Leadership also involves the process of one person influencing another in the pursuit of the common goal,³³⁻³⁵ As argued above, too much emphasis on autonomy both in goal-setting and in decisions concerning how to reach the defined goal, may be exhausting to the patient. We find that nurses often function as leaders in the nurse-patient relationship, as the nurses are given the responsibility to assess the patient's responses to their own health status and to ensure that the patients are given direction and movement towards the common goal of health, recovery and independence, and away from suffering and dependence.

Drath et al.³⁶ describe leadership in terms of three leadership outcomes and claim that the essence of leadership is in the leaders' alignment of knowledge and commitment, in addition to the production of direction and movement, and this definition also pertains to nursing. In nursing, nurses align their influence on patients through the organization and co-ordination of knowledge; the nurse has the expertise and knowledge pertaining to nursing, the context where the nursing occurs, and how to promote and restore health and prevent illness in patients in general. The patient has the expertise and knowledge,

pertaining to himself, on how he experiences the situation and his own values and goals. Nurses align these two perspectives when making discretionary assessments of patients' responses to their health status. The nurse-patient relationship also produces the commitment mentioned by Drath et al.,³⁶ as both patients and nurses are committed to the shared goals of preventing illness, restoring health and alleviating suffering in patients. Nurses are also committed to advocating for the patient through the nurses professional mandate. Thus, they are responsible for subsuming their own immediate interests and benefit to the patients benefit, and the nursing project when producing the direction and movement toward the common goals.

In the perspective of leadership, when patients need nursing, the patients are in need of movement toward health and recovery and away from suffering. In this perspective, it is the nurse's responsibility as the leader in the relationship, to exert influence on patients to ensure this movement and direction, as these are the common goals of the nurse and the patient. Not to exert such influence on the patient would be a disclaiming of one's responsibility as the leader in this relationship. Nudging may facilitate decisions and actions that may ensure and/or enhance movement in a preferred direction. As such nudging is a tool/an intervention that may be used to exert influence on patients, to ensure that they are moving toward the common goals.

In the perspective of leadership nudging is a tool that may be used to lead patients toward the common goal of health and recovery and away from suffering. As long as the decisions and actions the patient is nudged toward are not in conflict with the patient's values or explicit wishes, and the nudging is restricted to situations with minor decisions, we feel confident that nudging patients also safeguards the patient's dignity.

Conclusion: Nudging in Nursing

Rational assessments and decisions are highly energy intensive. Patients often have reduced capacity to perform rational decisions that override pre-rational inclinations. We should support patients' capacity to make autonomous decisions when confronted with major decisions. One way of accomplishing this goal may be by relieving patients from responsibility when they face minor decisions.

We have argued that situations where patients face minor decisions pertaining to performance of actions necessary for recovery and health, and prevention of complications and suffering, does not belong to the domain of informed consent. Rather, such circumstances belong to the domain where nudging is permissible. We think that the perspective of leadership is more suitable than the perspective of autonomy, when discussing nudging in these situations.

In the perspective of nursing as leadership, nudging is a useful tool or strategy for directing and guiding patients towards the shared goals of health, recovery and independence, and away from suffering. It may also help patients conserve and direct mental energy (will) for major decisions, where rational considerations are of greater importance. This approach does not mean that we support a strongly paternalistic view that disregards patients' wishes and values. The use of nudging in nursing, to influence

patients' decisions and actions, must be in alignment with the nursing project and in accordance with patients' own values and goals.

Declaration of Conflicting Interests

The Author(s) declare(s) that there is no conflict of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research has been funded by the Oslo and Akershus University College, and the Norwegian Research Council (Grant number: 250503).

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