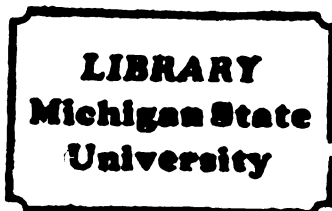




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THE RELATIONSHIP BETWEEN LEVELS OF MORAL/ETHICAL
JUDGMENT, ADVOCACY AND AUTONOMY AMONG COMMUNITY
HEALTH NURSES

presented by

Patricia G. Hatfield

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Education

Charles A. McKee
Major professor

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THE RELATIONSHIP BETWEEN LEVELS OF MORAL\ETHICAL JUDGMENT,
ADVOCACY AND AUTONOMY AMONG COMMUNITY
HEALTH NURSES

By

Patricia Gay Hatfield

A DISSERTATION

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ABSTRACT

THE RELATIONSHIP BETWEEN LEVELS OF MORAL/ETHICAL JUDGMENT, ADVOCACY AND AUTONOMY AMONG COMMUNITY HEALTH NURSES

By

Patricia Gay Hatfield

In this research there were two specific purposes. The first, was to determine the relationship between ethical/moral development and specific characteristics of the nurse: age, basic education, years of experience, place of employment, and ethical education. The second purpose was to determine if there is a relationship between the nurse's ethical reasoning and those factors which influence the nurse's ability to act autonomously as an advocate for the patient. Factors which were considered to be important were the nurses beliefs about patient autonomy, nurse autonomy and organizational support of ethical nursing practice. The population drawn for this study consisted of nurses employed in public health departments, home health care agencies, and hospices.

Three instruments were used within this study. The first was the Personal Data Sheet (PDS) which collected the demographic information about the subjects. The second instrument, Nursing Advocacy\Beliefs and Practices (NABP), was a questionnaire which measured nursing advocacy, patient advocacy and organizational support. The third instrument was the Nursing Dilemma Test (NDT) which measured four stages of ethical development, practical considerations and familiarity with nursing ethical dilemmas.

The major findings were that experience had a significant relationship to practical considerations at .05 level of significance for home health care nurses only.

Nursing principled reasoning and practical considerations had a negative correlation for nurses employed in health departments and home health care agencies. The correlation was at the .01 level of significance. There were no correlations related to practical considerations for nurses employed in hospices.

The assumption made in this study that an autonomous nurse would respect patient autonomy was correlated over all agencies. Nurse autonomy and patient autonomy were correlated at the .01 level of significance for nurses employed in public health departments, home health agencies and hospices.

The next finding related to organizational support and familiarity with the situation. The correlation between organizational support and familiarity was at the .01 level of significance for all agencies.

I wish to dedicate this dissertation to the community health nursing administrators and nurses who were willing to participate in this study and provided such complete information. Without this cooperation the study would not have been possible.

I also want to express my gratitude to my husband, Bob, who understood my dedication to this project and was emotionally supportive throughout the time the dissertation was in progress.

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CHAPTER 1

INTRODUCTION AND PROBLEM

Background of the Problem

In the education of a professional, many complex behaviors are considered necessary for safe and competent practice because of the potential for harm to individuals involved in interaction with a professional whether he/she is a lawyer, psychologist, social worker or nurse. Crucial to the process in professional education is the degree of cognitive (intellectual) and moral development needed to make decisions. In the education of professional nurses, major concerns relate to the possible harm to patients based upon the physical and psychological effects of nursing interventions.

Nursing in Community Agencies

This study examines the concept of advocacy in the context of community health nursing with a conceptual base derived from moral development and reasoning. Nurses in community health settings are confronted with ethical dilemmas frequently and consistently. How they respond cognitively to these situations varies greatly depending upon the moral/ethical reasoning of the individual nurse, the ability of the nurse to recognize and make the commitment to respond to the ethical implications of the situation, and degree of administrative support accorded to ethical concerns in nursing practice.

In public health agencies (health departments) nurses provide services to clients who may be victims of domestic violence, drug users, handicapped children, mothers and infants, school children, the homeless (the economically disenfranchised) and persons with communicable diseases, e.g. AIDS or tuberculosis. These services are generally supported by public funding (federal, state and county). Some health

departments provide home health care services also which would be financed by Medicare or Medicaid.

Nurses in home health care agencies provide services primarily to the elderly who require skilled nursing services on an intermittent basis.

Nurses employed in hospices provide care to the terminally ill. The services provided by both home health care agencies and hospices may be financed through Medicare, Medicaid, private insurance or the individual.

In all three types of agencies, services are usually required for a longer period of time than that provided to hospitalized patients and, the nature of the services are different than provided by acute institutional settings, i.e., the thrust of acute care is to restore the client to health within a short time, while services in the home are more rehabilitative in nature and concerned with restoration to self-care. Also, in community health nursing, there may be more involvement with family members. Care-givers (such as spouses, other relatives or friends) in the home setting may need education and counseling about protection from physical and mental stress in order to ensure that they continue to function as a caregiver. The nature of the patient's situation may evoke a response from the nurse which is ethical in nature due to the length of time that a relationship has to develop between the nurse and patient/family. Community health nurses stress teaching, demonstration, and health promoting behaviors of all members in the family.

Community health nurses have great opportunity to be autonomous and free to make practice decisions than nurses. They may be the sole provider of services in the home. To some degree the nurse has control

over the length of time she can spend with any one patient or family based upon his\her perception of need . Although patients in home care and hospice care have their services paid by Medicare or Medicaid, the services are provided by the nurse. Payment for services, although dependent upon physician authorization, are primarily for skilled nursing services. If the nurse can verify that the care provided is skilled nursing care or assistance to the dying, extensions can be granted for continued care. The community health nurse plans and utilizes her time based upon community priorities, specified program priorities and individual nursing care plans for individuals needing preventive, restorative or rehabilitation needs. These conditions provide an opportunity for the nurse to be autonomous in planning and carrying out patient services since he/she must make decisions outside the walls of an institution. In instances of need, administrative personnel can be reached by phone.

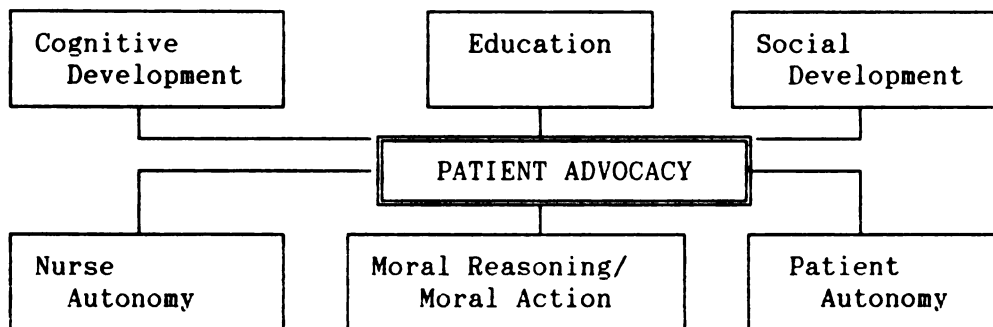
The authority which the physician exercises within the institutional setting has great impact upon the nurse's decision to act as an advocate. The nurse who opposes the view of a physician and exercises her moral responsibility to tell the truth to a patient or family member may well find herself unemployed. There is generally less physician oversight and or involvement in patient care services situations in which nurses in the community provide care.

The greater freedom from physician domination in community health may be due in part to physicians lack of understanding of what the nurse within the home setting actually does with patients and families. Medicine focuses upon the management of deviations from health while nursing more broadly focuses on health and illness. Families often desire the continued services and support that the nurses provide and

physicians are reluctant to say that services are no longer needed when families say they have continued needs. Agencies have the responsibility to determine whether the patient meets the federal guidelines for continued care.

Schematically, the model used in this study includes elements consisting of factors which need to be considered that have impact upon the decision to employ ethical principles in the practice of nursing. The following table illustrates those factors.

Figure 1
Elements Influencing Patient Advocacy Role



Advocacy as an ethical model in nursing is widely written about in the literature and promoted for nursing practice. There are three major categories of advocacy in nursing: (1) confrontation with health care services or agencies for access to services which directly affect the community-at-large; (2) group advocacy which is undertaken on behalf of a smaller well defined population, e.g., the physically disabled and, then, (3) direct patient advocacy which involves the nurse in assisting the patient to resolve a dilemma in their personal health care (Kohnke, 1982, p. 317).

This study will explore only the theoretical concept of direct patient advocacy (DPA) as described primarily by three authors (Gadow,

1981), (Pinch, 1985) (Chapman, 1975). The focus of the study will be upon the concepts of advocacy, autonomy (patient and nurse), and organizational support as related to ethical/moral reasoning. The study population will be drawn from nurses employed in community health agencies (public health, home health care and hospice) and their perceptions of autonomy (patient and nurse) and organizational support as related to advocacy.

Condon (1988, p.24) believes that person, environment, health and nursing are bound up in relationships which are interpersonal, ethical, legal and political.

Definitions of Advocacy

There are many definitions of patient advocacy. The dictionary (1968) defines an advocate as "a person who pleads for or in behalf of another; intercessor." This definition of advocacy implies independent action on the part of the advocate which could include a variety of functions that may force the nurse into situations that could be professionally risky. The concepts of assertiveness, risk-taking, power, human rights and dignity, noncompliance, and involvement are entangled in advocacy and would require not only an understanding and support of these but also a commitment (Donahue, 1985, p.342).

The dictionary definition is the common understanding of the concept of advocacy. Benner (1984) reflects this understanding when she states,

Patients and families frequently need the nurse to run defense for them. They may be mystified by the medical jargon, or their understanding may be blocked by fear. The nurse can interpret patient to doctor and doctor to patient. I call this kind of power advocacy power. (p. 212)

Archer (1979, p.11) shares this view of patient advocacy by defining the community nurse's role as one in which she assists clients

to obtain what they need and are entitled to from other persons or agencies. A second function of the nurse in this definition is to make the system more responsive to clients needs "either in particular cases or in general." These definitions tend toward a paternalistic mode of intervention.

In this study, direct patient advocacy (DPA) will be defined as an ethical response of the nurse in actively assisting patients in their free self-determination of treatment options; to help individuals to become clear about what they want in a situation, to assist them in discerning and clarifying their values, and to help them to examine options in the light of their values. In the patient advocate model as described by Pinch (1985):

The nurse considers her moral authority to be as great as any other health professional and considers her first responsibility is toward the patient as a unique human being. [The nurse] facilitates the patient's efforts to obtain whatever care is needed, even if it means going against the doctor or the hospital administration. (p. 372)

Thollaug has defined patient advocacy as a kind of reform movement which restructures the relationship between providers and consumers according to the interests of the latter. The challenge to each nurse is that he/she conduct his/her own practice with the patient as the main focus and the first priority (Donahue, 1985, p. 342).

Current nursing beliefs about advocacy support a very different and more comprehensive view of the role of an advocate based upon factors influencing nursing practice, e.g. law, ethics, nursing models and theories, and professional standards and codes. "Advocacy has moved from a posture of interceding, supporting or pleading a case for a client to acting as guardian of the client's rights to autonomy and free choice" (Nelson, 1988, p.136).

Donahue (1985, p. 340) contends that early nurse leaders were patient advocates who were concerned about and committed to human rights, dignity, humanitarianism, and accountability. Embodied in their definition of nursing were the concepts of autonomy, advocacy and independent practice, which focused on the prevention of illness as well as the maintenance of health. These ideas are still in tune with current thought regarding advocacy and provide a holistic, humanistic theme to nursing care.

Curtin (1978) states that:

The concept of advocacy ... is not the concept of the patients' rights movement nor the legal concept of advocacy, but a far more fundamental advocacy founded upon the simplest and most basic of premises. This proposed ideal of advocacy is based upon our common humanity, our common needs, and our common human rights. We must act as human advocates, assist patients to find meaning or purpose in their living or dying..Whatever patients define as their goal, it is their meaning and not ours, their values and not ours, and their living or dying, not ours.

With the assistance of the nurse the patient comes to a point of understanding regarding his/her rights; options related to his current illness and treatment; and after reflection and review makes decisions based on his own values, knowledge and beliefs about what his care and treatment should be and an understanding of what his/her involvement will be. (pp. 3-5)

Kraus (1981) states, "that advocacy is expert professional care that is tailored to the specific needs of the patient and his family as the advocate coordinates and humanizes what would otherwise be fragmented, impersonal interventions."

Kohnke (1980, 2038) defines advocacy as "the act of informing and supporting a person so that he can make the best decisions possible for himself." She cautions that the patient has a right to make decisions freely without pressure. If the nurse is not able to allow the patient the ability to choose freely, advocacy is not occurring, it is rescuing.

Chapman (1975) proposes a model of advocacy based upon humanistic values and states that:

...effective helping is ultimately defined by the patients. Whether they have been helped is decided perceptually - by how they perceive themselves "to be" after the interventions sought from another. (p. 29)

In this advocacy model, the actions of the professional are determined by the patient and the situation in which both individuals find themselves. Both parties are actively involved in goal setting, and in determining what circumstances responsibility can and cannot be taken in behalf of another (Chapman, 1975, p. 40).

Gadow (1979) takes an existential view of advocacy which "...is based upon the principle that freedom of self-determination is the most fundamental and valuable human right" (p. 81). In this view advocacy nursing is described as:

... the participation with the patient in reaching decisions regarding the management of an illness. At a more fundamental level, however, we must recognize existential advocacy as the nurse's interaction with the patient in determining the personal meaning that the experience is to have for the patient (p. 83).

The concept of advocacy to be explored in this study will be that advocacy actions on the part of the nurse are based upon a firm understanding of the ethical foundations which underlie the type of dilemmas and patient situations which she/he faces in practice. Foremost among these ethical principles are the rights of patients to self-determination and freedom from paternalism. This type of advocacy puts aside negative feelings toward patients and families and the "I know best" attitude" which is frequently employed when the nurse confronts patient and cultural behaviors which are different from her/his own beliefs.

In addressing the issue of paternalism in health care, Veatch

(1984) states that:

Respect for the person differs from simply doing what one thinks will benefit the person even if others can really determine what will benefit the person. It is not that benefiting the patient is morally irrelevant -of course not, and hard work is in order to determine what will benefit - but, rather, in the case of autonomous human beings, respecting their free choices must take precedence.

...Respecting the patient's autonomy always takes precedence over benefiting the patient against the patient's autonomous will (p. 38).

All of the authors rely heavily upon examination of ethical dilemmas and the principles of ethics as the stimulus for action on the part of the nurse. Currently, advocacy is more frequently mentioned in the nursing literature as a part of the nurses practice. Donovan (1989) states:

As the demographic profile of the population changes, we're seeing a shift toward less costly modalities of treatment. We're looking at a more educated consumer who's asking a tough question, "Is this the only way to do it?....Among the trends are continuing efforts to resolve problems with health-care financing, the nursing shortage and expansion of nurses' roles in health care.

Nurses will continue to be health care educators and advocates for patients and will continue to promote alternative methods of treatment including preventive strategies and health promotion interventions. (p.26)

Condon (1988) believes that:

The significant moral concept of advocacy..informs the nurses caring and ..tends to direct the nurse's autonomy and professionalism toward promoting the good of the patient. Advocacy is an explicit moral value of nursing's culture (p. 26).

Factors Within Society Which Influence the Need for Advocacy

Increasingly there are changes in our society and within the health care professions which impact upon systems to alter or increase the type of interventions employed in maintaining health or treating illnesses.

There are four primary sources of change in society:

1. demographic
2. sociocultural
3. economic, and
4. political. (Hillboe 1968, p. 1589)

These sources of change strongly influence health care systems and the health care professionals' responses in providing services. Many of these influences impact upon the need for professionals to utilize an ethical/moral orientation in providing services to patients.

A fifth influence which strongly influences the practice of nursing are the professional standards, ethical codes and legal definitions of nursing practice. A sixth major concern in today's society is the advent of technological innovations which change the definitions of life, death and dying.

Using Hillboe's classification, Clark (1984, p. 463) has organized and identified within the four categories the factors which are currently of major concern and in need of different interventions to address the needs of people.

Demographic Factors

Increased population places an increased demand upon the health care system; the type and numbers of professional resources needed; and new strategies to be utilized to address problems unique to the present time and in anticipation of future needs.

The increased longevity of the population (11.3% of the population is over 65 years of age) results in increased demand for preventive, diagnostic, and treatment resources to combat and treat chronic disease and disability. Rehr (1978) raises the question, "do we not require of our elected representatives that their decisions be tempered with

justice, humanity, and the ethical values inherent in our social structure and our common law?" In addition she states,

Currently, there is an attitudinal, judgmental aspect, which leads almost no one to want to care for the aged: their families reject them; acute care hospitals only want them while they are sick, treatable, and interesting; the government is interested in cost controls; and, third parties commonly refuse to underwrite preventive and or/ambulatory care. ... Can we have a "practice success" but an "ethical failure?"

The practice of gerontology and gerontological nursing have evolved in response to the growing demand. The problems of longer life, greatest disabilities, and the inability of families to provide the necessary services has resulted in the need for new disciplines which can provide the level of care needed by that population referred to as the "frail elderly." (A more appropriate term might be "fragile elderly" because it could refer to both the physical and psychological status of individuals and then would include the growing number of Alzheimer diseased persons.

The demands that dementia patients will place on the health care system over the next half century will increase significantly. In that time, the population of roughly 2.5 million moderately to severely demented persons will nearly triple. The annual cost of care of \$24 billion to \$48 billioncan be expected to grow to 10% of the nation's annual total health care expenditure (Duffy, 1989). Duffy further predicts that home care of dementia patients will be in demand with many more severely demented patients needing home health agency nurses for chronic care.

Nurses in the community, especially in home health care and hospice services, could benefit from consultation provided by gerontological specialists.

Often when families attempt to care for elderly parents in their

homes they are denied assistance from nursing agencies based in the community because these patients do not meet the Medicare requirement for a skilled level of care. This means that children, who are themselves aging, are left to provide for their parents as best they can with little or no assistance.

The large number of young people (21 million between the ages of 14-19) have created problems in the areas of sexually transmitted diseases, accidents, and suicide.

Each year 600,000 children are born to teenage mothers and 1.1 million abortions are performed. Four percent of the 3.3 million live births in the U.S. are comprised of infants who have multiple congenital anomalies. An additional 7% (230,00) of infants weigh 2500 grams or less at birth (Martin, 1985). The problem of severe congenital conditions raises the question of "Is withholding of treatment a benevolent act of compassion or it an act of murder?" The Federal Child Abuse & Prevention Act of 1974 has indicated that treatment may be withheld if:

1. the infant is chronically and irreversibly comatose,
2. the treatment will merely prolong dying,
3. the treatment would be futile in terms of the infants survival and the treatment itself would be inhumane (Martin, 1985, p. 48).

The dilemma of these babies are raising profound questions about the quality of life, death and dying, and are requiring that we look to ethical decision-making constructs to ensure that the rights of those who are unable to speak for themselves, have voices raised in their behalf. These infants are often cared for in the home setting (if they survive their disabilities) and the complexity of their care and the ability of parents to handle the physical and emotional obstacles to

development present complex nursing problems and call into question ethical principles for the nurse such as "do no harm" and justice.

Drug use and abuse have had profound effects on individuals, neighborhoods, and society. Babies are born addicted to cocaine, school children are drug users, parents are unable to economically provide for, nurture, or otherwise care for their children due to their involvement with drugs.

Public health nurses who visit schools see the results of drug addiction on both the children (who may or may not be users) and the effect of having parents who are not responsive to the developmental needs of their children because of their addiction.

Community health nurse nurses are sometimes the first persons to recognize abuse and neglect of children and elderly adults. Often the nurse experiences much discomfort in attempting to balance ethical considerations and comply with legal requirements of reporting instances of neglect and abuse. These situations raise the question of "advocate for whom?" and the principle of "do not harm."

Technological Change

With the use of technology, we have increased the ability to prolong life through transplantation of organs; increased handicapping conditions (250,000 babies with handicapping conditions are born each year); and have raised questions as to how human life is defined, at what time does life begin and when do living organizations attain and have the right to life and to health care? (ANA, 1985).

Other technological innovations influence the length of life, such as early death due to pollutants in water, air; adulteration of food; and antibiotics fed to livestock which eventually may pose a hazard to human life.

Mechanic contends that the American health care delivery system has moved from advocacy to allocation. The high cost of technological innovation forces attention to the moral issue of what is the just and equal distribution of the new and costly technology, i.e. how is it to be allocated? (cited in Leddy, 1989).

Leddy, (1989) in a constructive view, states that "nurses have great opportunities to assist clients to have the advantages of the improved technical supports and to ensure that care is distributed in a just and equal manner."

Decisions about who will have transplantation of organs and who will not are allocation problems, as well as, who is able to have the services of a renown cardiac specialist and who will be denied. As allocation decisions are made who supports and interprets to potential patients and their families the types of mental review and clarification of the issues involved in such complex decision-making and who protects their right to choices? In referring to technology, Zwolski (1989) contends that,

Nursing must be aware of the client's vision [goal] and protect that vision. Herein lies the real meaning of the nurse as patient advocate. To respect the rights of clients and be able to protect them in a technical system, professional nurses need to make an effort to continuously assess the techniques in relation to each individual client and to ask the question, What is the good of this technique for the client and under what conditions should it be used? Sometimes it should not be used (p. 240).

He further states that:

Technical systems exist not only in acute care settings but also characterize community based health care systems. In viewing technical systems, certain themes regularly recur. These themes are the use of alternate techniques, the allocation of resources (distributive justice), ethical concerns, issues of control and autonomy, advocacy, education and creativity (p. 243).

Part of the advocacy functions that the nurse needs is reflected in the statement:

As individuals who may become patients ourselves, most of us want more than technical competence when we are sick; we want the empathy of another human being, whether we suffer from a slight cold or terminal cancer (Palmer, 1989, p. 7).

Herdman (1985) states that questions about the use or misuse of technologies, our understanding of what they can do, patients' rights and the ethical situations involved are part of public debate. In focusing upon the nurse, Herdman states:

...It is the nurse who best knows the patient's wishes, the patient's condition, and the patient's family. A more independent role for nurses in the provision of health care would help, when this can be achieved. Also better grounding in technology assessment and basic ethics would go a long way toward according nurses a more authoritative role in the debate. If this is being done, it is surely not well known. What one often hears about is disputes between physicians who are reluctant to actually "pull the plug" themselves and nurses who are not in a strong position to debate the issue (p. 23).

Community health nurses are involved in learning, using and teaching more complex procedures and the use of technology in the home such as monitors for Sudden Infant Death Syndrome (SIDS) babies and ventilators for the comatose. Educating families to understand and be alert to problems related to technology such as parental feeding and intravenous drug administration is increasingly part of the community health nurses practice as patients and families elect to keep family members at home. The themes described by Zwolski are becoming a growing concern as patients make choices to have care in the home and, sometimes, to die there with care from a hospice nurse. Nurses who work in hospices generally are assisting patients, and in the case of incompetent individuals, families to provide care to terminally ill patients in their home. These individuals have elected to shun extreme

measures to sustain life. Chief Justice Gordon, Arizona Supreme Court, discussed the dilemmas of this trend by saying:

Not long ago the realms of life and death were delineated a bright line. Now this line is blurred by wondrous advances in medical technology—advances that until recent years were only ideas conceivable by such fiction writers as Jules Verne and H. G. Wells. Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity. As more individuals assert their right to refuse medical treatment, more frequently do the disciplines of medicine, law, philosophy, technology, and religion collide. This disciplinary interplay raises many questions to which no single person or profession has all the answers (Meisal, 1989, p. vii).

In the meantime, nurses who work within institutional settings and those in the community provide care and support to the patient and their families and deal with the ethical dilemmas raised by the dying in today's society. Nurses in home care are beginning to address the ethical demands of their occupation as they reflect that:

Ethical problems occur in home care populations across the life span from ventilator-dependent infants to elderly patients who may not be competent to make decisions in their own best interests...There are several examples of situations that raise more specific ethical questions. These situations raise questions about what **ought** to be done and what can be justified morally.

Technical/professional expertise alone is not sufficient to deal with the ethical aspects of nursing practice when moral principles...are at stake and staff nurses are struggling to decide what they **ought** to do in client care, or agency administrators are trying to develop more ethically adequate policies (Martinson & Widmer, 1989, 382).

Sociological Changes

The concept of health care as a right and health as a positive state rather than the absence of disease has changed society by increasing the numbers of better informed clients due to rapid dissemination of information through magazines, newspapers, radio and

television. Exercise has been endorsed by all segments of society and changes in diet (lower cholesterol, fat, and sugar and higher fiber) has made producers of food items aware of the demand of a growing market for products that will lessen the risk of chronic disease.

Health promotion services have increased and can be found in industrial sites and shopping malls, as well as physician offices and clinics. Health screening for glaucoma, hypertension, cholesterol and diabetes is recommended and people are securing these tests in sites outside of physician's offices.

The adverse effects upon health of the women's liberation movement which has resulted in increased stress ("the superwoman syndrome"), alcoholism, drug abuse, lung cancer, and mental health problems influence health care services such as the growth of women's health centers, exercise and diet centers.

The pace of modern life and the increase in leisure time have contributed to accident rates.

Simms (1984, p. 45) views consumers of health care as wanting more control of their own health and wanting to assume responsibility for present and potential health care needs. She states that patients reject the role of passive recipient with health care workers making their decisions for them without their input.

Nurses working in the community realize that they gain entry into homes through the willingness of the families they visit to allow them entry. On the other hand, they also recognize that when their services do not correspond to the goals of the individuals they are visiting, they may be asked not to return. This recognition on the part of the nurses helps them to be conscious of the need to render services that are in concert with the desires of the patient and family. On the

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other hand, the community health nurse has great opportunities to assist families to become their own advocates as they interact with the medical care system regarding their health practices and self-care activities. Patients need this information regardless of the setting where they receive their health care services but nurses providing services within the home have the opportunity to observe not only what the family says they do but also what they do. The ability of community nurses to allocate their time based upon perceived patient needs is more flexible than the time of nurses in institutional settings.

Economic Change

The standard of living for Americans has increased while at the same time the cost of health care has increased resulting in a maldistribution of health care services and professionals.

Self-help groups have developed outside the main stream of professional services, e.g., mental health groups. Health centers for the poor have been established and food centers for the hungry and homeless have increased. Shelters have been established which provide not only housing but health care services also.

Partly due to economic conditions, such as the inability to finance long term care, and partly due to changing attitudes toward the type of care provided, there has been a shift in where care is given (e.g., home care, hospice, and day care centers for seniors, abortion clinics, mental health services and family planning services).

Public health nurses have been involved in planning services for the homeless, the mentally ill, displaced homemakers (victims of domestic violence and abuse), and store front clinics. In addition some nurses may have an assignment in which they will work with other professionals in providing direct services to these disadvantaged

individuals. Their advocacy in these situations are compassion, helping persons to develop self-esteem and progress to an understanding that they do have choices in life. Through techniques such as values clarification and problem solving, they enable people to draw upon their strengths to reorder their lives in a productive fashion. They assist people to find resources outside the health care system that will provide services they need, such as financial programs, housing, and food resources.

Political Change

The provision of Medicare/Medicaid has increased access to care for the elderly and poor but has created a crisis for some middle-Americans due to inability to provide adequate insurance coverage to maintain the family. Some businesses are attempting to insure workers directly. The growth of health maintenance organizations which attempt to modify large insurance costs through keeping their members healthy has shifted the focus of care to prevention, early intervention and away from the need for hospitalization.

Law suits against health practitioners increases the cost of health care. Malpractice suits have decreased accessibility to health care for those in need of orthopedic and maternal health services.

The government and law are entangled in dilemmas related to abortion and parental rights in family planning services for minors. The abortion issue has become a political see-saw. Women seek abortion; women oppose abortion; men ask for their rights in decisions affecting their unborn children and government ponders the social and economic ramifications of a growing dilemma. Because of strong citizen advocates for both sides of the abortion issue, the law undergoes change. The dichotomy created by the parents' belief that they should be consulted

when their children seek family planning services and those segments of society who believe that restriction creates a denial of access to needed services presents another situation where legal responses swing back and forth due to the pressures placed on legislators.

The Cuban, Mexican and Vietnamese populations place greater demand on health services. The need for the nurse to understand health beliefs, cultural patterns, language and the right of individuals to hold certain beliefs and maintain their own practices is greatly increased. In working with populations who hold views contrary to those of the community health nurse, it is important that the nurse recognize those ethical/moral beliefs of "self-determination, independence, and choice in decision making in matters of health".

All of these political and legal factors have contributed greatly to a recognition of need for greater ethical/moral considerations in health care and attention to legal influences upon the health care system in terms of laws regarding abortion, right to life, right to die and living wills. The nurse who practices as an advocate in these situations needs to understand the meaning of the patient's and families' experience as they interact with the various professionals who will recommend, urge, support or withdraw support in difficult situations which are truly ethical dilemmas faced by persons currently. Nurses practicing in hospices are working with individuals who have made decisions about their death and nurses who elect to work with dying persons need to reflect on their ethical and personal beliefs about mortality in order to effectively support patient choices.

Factors Impacting on the Profession of Nursing

The practice of nursing is subject to legal requirements, professional standards, professional codes and ethical standards.

Legal Standards

The practice of nursing is regulated by law. The purpose of a licensing law is to protect the health of the people by establishing minimum standards for qualified practitioners to meet (ANA, 1958).

In Michigan, the practice of nursing is defined as:

... the systematic application of substantial specialized knowledge and skill, derived from the biological, physical and behavioral sciences, to the care, treatment, counsel and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability (Public Health Code, p. 269).

While the practice of medicine means:

The diagnosis, treatment, prevention, cure, or relieving of human disease, ailment, defect, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering undertaking, attempting to do, or holding oneself out as able to do any of these acts (Public Health Code, p. 258).

Therefore nursing is defined as having an interest in and an obligation to address both health and illness while medicine has a focus upon the management of deviations from health.

Professional Standards and Codes

In defining the nature and scope of nursing practice, the American Nurses Association describes nursing as, "the diagnosis and treatment of human responses to actual or potential health problems."

Ethical Statements

Professions generally have written statements which guide ethical practice. In nursing, these ethical principles are stated as:

- respect for persons and their inherent worth and dignity
- autonomy (self-determination)
- beneficence (doing good)
- non malfeasance (avoiding harm)
- veracity (truth telling)
- confidentiality (respecting privacy of information)
- fidelity (keeping promises)

--justice (treating people fairly) (ANA, 1985,)

Ethical statements for nurses are contained in the American Nurses' Association Code for Nurses with Interpretive Statements. The first statement is that, "the nurse provides services with respect for the dignity of man, unrestricted by considerations of nationality, race, creed, color or status." Further clarification is provided in the interpretative statement:

The nurse's respect for the worth and dignity of the individual human being extends throughout the entire life cycle, from birth to death and is reflected in her care of the defective as well as the normal, the patient with a long term in contrast to an acute illness, the young and the old, the recovering patient as well as the one who is terminally ill or dying (ANA, 1968, p. 3).

The second statement refers to the responsibility of the nurse to "safeguard the individual's right to privacy by judiciously protecting information of a confidential nature." The interpretative statement is:

...The nurse-patient relationship is built on trust; this relationship could be destroyed and the patient's welfare and reputation jeopardized by the nurses injudicious disclosure of confidential information (ANA, 1968, P. 2).

In Nursing: A Social Policy Statement, the following statements illustrate concepts related to the ethical practice of nursing:

Nurses are guided by a humanistic philosophy having caring coupled with understanding and purpose as its central feature. Nurses have the highest regard for self-determination, independence, and choice in decision making in matters of health. Nurses are committed to respecting human beings because of a profound regard for humanity. This principle applies to themselves, to people receiving care, and to other people who share in the provision of care, as well as to humanity in general. This basic commitment is unaltered by the social, educational, economic, cultural, racial, religious or other specific attributes of human beings receiving care, including the nature and the duration of disease and illness (1980, P. 18).

A document entitled Code of Ethics for Home Care (1984) describes

client rights and responsibilities. Client rights in this document includes (among other rights) information about agency policies; informed decision-making about procedures or treatments; the right to refuse treatment; data privacy and confidentiality; a right to voice grievances without fear of reprisal and timely information about anticipated termination of service. (Stanhope, (1984), 792).

Nursing practice as described in these laws, professional standards and ethical codes are considered to be the same regardless of where nurses are practicing or their specialty designation. This means that all nurses are bound to an understanding of how their practice should conform to the dictates of their profession. Their relationships with patients are considered to be the same whether they work in a hospital or in a hospice. Therefore, their interventions are not determined by place of employment but by the dictates of the profession, i.e., if patient advocacy is recognized as an ethical model for nursing practice it is not confined to those practicing in hospital settings alone.

Differences in practice in public health nursing, home health and hospice care (as opposed to hospitals and nursing homes) are (1) less bureaucratic constraints, i.e., more autonomy on the part of the nurse in determining priorities for patient care; (2) more flexibility in the frequency of visits and the amount of time she may spend with clients and families based upon patient/family/nurse perceptions of need; (3) reduced reliance upon physician direction which occurs in institutional settings and (4) focus upon the factors which influence the health of individuals. Aroskar (1979, p. 35) indicates that the moral concern of nurses in all settings are similar, i.e., truth-telling, paternalism, coercion, self-determination, and allocation of scarce resources.

Community health nursing is more focused upon the social dimensions of ethics i.e., the subsystems of society with which it deals.

Nursing Models and Theories

Early models or theories in nursing have laid the ground work for the nurse to incorporate the role of client advocate as an aspect of her nursing practice. Theories of nursing usually revolve around four concepts. Humanity, health, society and nursing are usually embodied in nursing theories (Belcher, 1980, p. 74).

The concept of advocacy is interwoven into theories and conceptual models of nursing which provide direction for professional nursing practice. Although these cognitive configurations may or may not identify advocacy specifically they do embody ethical/moral principles which are important in nursing care situations and, especially, in nurse/patient interpersonal relations. Respecting patient's rights, viewing the patient as subject rather than object, involving the patient in decision making, informing and supporting while difficult choices are made, ensuring that no harm comes to the patient, and treating people fairly are concepts that are included in the models described. These principals frequently promote the need for adversarial actions on the part of the nurse.

Cognitive and Social Learning Theories

Kohlberg's (1976) research with children and young adults led him to believe that moral reasoning and cognitive thought are intimately related in a complex manner.

...since moral reasoning clearly is reasoning;
advanced moral reasoning depends upon advanced logical reasoning; a person's logical stage puts a certain ceiling on the moral stage he can attain...While logical development is necessary for moral development and sets

limits to it, most individuals are higher in logical stage than they are in moral stage (Rich, 1985, p. 95).

Rest suggests that moral judgment is one component among four components in the production of moral behavior. That is, in order for someone to perform a moral act, four distinct processes must have taken place: (1) moral sensitivity, (2) judge a course of action as the moral thing to do, (3) moral motivation, and (4) persistence of follow through. Rest studied junior high school students through college students, seminarians, and political science doctoral students. The study showed that 45% of the college students, 60% of the seminarians, and 93% of the doctoral students used principled thinking predominantly. Only 2.5% of the junior high school students used principled reasoning predominantly. (Mayberry, 1986, p.78)

Crisham (1981, p. 33) in a study of groups of nurses, college prenursing students, and graduate level nonnursing students in education had a similar finding to Rest's. The group with the highest level of education had the highest principled reasoning score.

An additional concept to be considered needs to be the social environment in which persons carry out their work and can be an influence on the decision-making of an individual. Turiel(1983), in speaking of social knowledge and emotional development, suggests that:

At some times and in some situations it may indeed occur that social system or institutional practices are in contradiction with moral practices. Assuming that individuals do form a core set of concepts of justice, welfare, and rights, such institutional practices may produce conditions for potential conflict. It should be kept in mind that the data have shown the coexistence of strong social organizational concerns and moral concerns (p. 26).

In light of the relationship between the organization and the concept of autonomy, the nurse may be in a controversial situation which places her obligation to the patient in an opposing position to her

place of employment or administrative staff. This raises questions of how do moral reasoning and development relate to supervisors support or non-support of advocacy?

Another concept related to moral development is moral distress. Moral distress is defined by Wilkinson as,

The psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicted by that decision (1987, p.16).

The structure and organization of an institution may determine the degree to which employees once having made a moral decision feel that they can carry out the required action. Will they be supported in doing so?

Rest (1976, p. 206) states that the developmentalist sees cognitive structure as the framework by which affective experiences are interpreted, and by which the strong, emotional experiences of today are translated into the commitments of tomorrow. Of interest to theorists in cognitive development are a person's basic problem-solving strategies and structural organization.

Cognitive developmental theorists have defined stages of moral development. Probably the most widely known are the developmental stages proposed by Kohlberg. There are three levels identified in Kohlberg's theory with two stages in each level: (1) Preconventional Level, (2) Conventional Level, and (3) Postconventional (Autonomous or Principled Level). Stages 1 and 2 are characteristic of children, stages 3 and 4 are ones at which most adults operate, and stages 5 and 6 have no more than 20-25% of the adult population reaching stage 5 and 5-10% at stage 6 (Subsequently, Kohlberg dropped stage 6) (Rosen, 1980). Kohlberg claims that advanced moral reasoning depends upon logical reasoning - it

is necessary for moral development and sets limits to it; however, most individuals are higher in logical stage than moral stage (Rich, 1985, 89).

In addition to intellectual development, Kohlberg asserted that social and education climates are thought to be crucial; climates that provide opportunities for group participation, shared decision making, and assumption of responsibility for consequences of action stimulate moral judgment development (Ketefian, 1981, p. 100). Wilson (1976, p. 22) believes that cognitive development is assumed to be one necessary but not sufficient condition for mature moral reasoning in the sense that such reasoning involves a developing capacity to integrate information and to generalize from one concrete actual situation to many. Mature moral orientations cannot occur without cognitive development, but the existence of mature morality is not determined by cognitive development alone.

Social learning theorists place special emphasis on the ways in which the environment impacts upon the individual. Moral orientations are considered to vary for different types of behavior and for the milieu in which that behavior takes place. Mature moral orientations are simple behavior, feeling, and cognition that are in conformity with those values of a social system that are evaluated positively by its members. In definition, a mature moral transaction is one in which (1) both known and unknown others are recipients without distinction for one's own positively evaluated behavior (one does not identify only with specific individuals or groups of individuals as legitimate recipients without distinction for one's own positively evaluated behavior); and (2) one's interaction with others will be such as to encourage them (by persuasion, modeling, etc.) to behave according to the same set of

positively evaluated standards. (Wilson, 1976, 124).

A Brief Review of Research Findings
on Moral Development in Nursing

Murphy (1976) measured moral reasoning levels of nurses who held different positions of authority in hospital and public health practice settings. While type of education was one her not one of her variables, she found no significant differences between her two groups; only 5% of her sample (120 nurses) used stage 5 as their modal stage of moral reasoning. She contends that:

...to function optimally and independently in a complex milieu and to act as responsible and accountable moral agents, nurses need to have attained a postconventional level of morality and that conventional morality is dysfunctional (p. 593-B).

There were no overall differences in levels of moral reasoning among nurses working in different types of environments and positions of authority.

DeJong (1985, p. 792-B) in examining the extent to which moral reasoning and perceptions of autonomy contributed to explaining moral judgment when intelligence was controlled found that moral reasoning was not significantly related to ethical judgment, and nurses who perceived themselves as having autonomy at work, believed that nurses in dilemmas would make ethical decisions.

Crisham (1985, p. 105) verified the significance of formal education and previous involvement with similar dilemmas in enhancing principled thinking and raised questions about the relative strength of practical considerations in the hospital milieu.

Ketefian (1989, p. 514) using the Judgment in Nursing Dilemmas found that when groups were examined in terms of differences in personal and professional variables, such as education, experience, work

setting, area of practice or position, the only noteworthy findings related to education. She also found, however, that nurses do not sustain their level of moral development within the context of the work setting.

Gaul (1986, p. 4113-B) raised the question "What is the relationship between practicing nurses' level of moral reasoning and ethical decision making in nursing practice?" Using a sample of 132 practicing registered nurses, she found that 39% reasoned at principled reasoning level. This means that 61% of the nurses reasoned at the conventional level or less. She concluded that the level of moral reasoning of practicing registered nurses is predominantly concerned with issues of reward and punishment and with preserving the existing power structure. She believes that registered nurses know the correct ethical decision but pragmatically they may not choose it.

Summary

Factors within society which influence the need for advocacy have been identified as: (1) demographic, (2) sociocultural, (3) economic, (4) political, (5) professional standards, ethical codes and the definition of practice, and (6) the impact of technological innovations which change the definitions of life, death and dying. These factors have been used to illustrate the importance of exploring advocacy in nursing practice, especially public health, home health care, and hospice care.

Factors which influence the nurses' ability to make ethical judgments, function autonomously as a professional person and as an advocate for the patient, are:

1. The basic education of nurses in ethical decision-making.
2. Levels of moral development among women and men who

practice in nursing.

3. Recognition that a patient situation requires that the nurse make an ethical choice and determine the content of that choice. (Does it involve patient autonomy, nurse autonomy, or organizational support?).
4. The amount and type of support that health care agencies provide for nurses in responding to ethical dilemmas.
5. The degree of autonomy accorded the nurse in decision-making and patient advocacy interventions by employers.

To understand whether nurses are prepared to function as advocates, it is critical to know the nature of the relationships among these personal, organizational and social influences. What factors **foster** or **deter** the nurse from using the advocacy model?

These influences could be conceived of as positive, i.e., the basic education of the nurse could have prepared her/him to adequately address ethical issues or, negatively (barriers), the educational program may not have dealt with ethics in any substantive way, thereby, leaving the nurse without the necessary skills to identify a problem as an ethical one. Another example would be, that the type of agency or the administration within the agency may or may not support the advocacy model. In community health nursing agencies (public health, home health care, and hospices), there are different types of care delivered to clients with different needs. These agencies operate under different policies, different financial systems, serve different populations and respond to different pressures.

There have been many studies of ethical/moral development using cognitive moral development theories. There is a significant body of knowledge in the area of moral development which has been generated by Kohlberg (1984), Rest (1986) and Gilligan (1982). Initially nurses studying moral development used the instruments of these researchers in

their work. In the intervening years, nurse researchers have developed tools based upon the works of these authors but more specifically directed toward nursing dilemmas to measure moral reasoning and ethical practice. Ketefian (1989), in an article in Nursing Clinics of North America, has reviewed nine instruments to measure moral reasoning and ethical practice developed for nursing studies.

Although many measures of moral reasoning have been undertaken by nurse researchers, few have been done using community health nurses as subjects. Wood (1986), using an instrument developed by Pankratz, compared community health nurses with baccalaureate prepared nurses, senior-level generic nursing students, and registered nurses in a baccalaureate nursing program on age, years of employment in nursing, and three variables of professional autonomy: nurses' rights and responsibilities, the nurse-patient relationship, and nurses' role in health care delivery. The assumption was that community health nurses are frequently required to intervene on behalf of patients, to assist clients in identifying health care alternatives, and to promote selection of alternatives most aligned with the patient's values and beliefs. Wood (1986) found that there were no statistical significant differences between community health nurses and student nurses. In explanation, she postulates,

We can only speculate that baccalaureate education may promote stronger beliefs about patients' rights (autonomy) than alternative programs. We also suggest that practice setting may be a major factor affecting nurse's beliefs about patient rights (p. 139).

Do nurses who have the opportunity to practice autonomously in the planning and intervening with patients and families hold more favorable beliefs about the autonomy of others, i.e. if the nurse values self-determination and freedom of choice, will he/she respect the rights of

patients to make choices also?

Chapter 2

REVIEW OF THE LITERATURE

Cognitive Learning Theories in Moral Development

The study of morality consists of social norms of behavior, whereas, ethical theory consists of the philosophical reasons for or against a set of reflections about morality. Philosophers seek to justify a system of standards or some moral point of view on the basis of carefully analyzed and defended theories and principles (the concept of justification). Respect for autonomy, distributive justice and beneficence are principles which are common in moral philosophy (Beauchamp, 1989, p. 10).

Moral judgments are justified by giving reasons for them. There are also different levels on which justification proceeds. A moral judgment is a decision, verdict or conclusion about an action or character trait. Moral rules are general guides governing actions. They determine the "oughts" and "ought nots" in particular cases. An example of a moral rule is "It is wrong to deceive patients," but the principle of respect for autonomy may be the basis of several moral rules of the deception-is-wrong variety. Moral principles are more fundamental than rules and serve as the justifying reasons for accepting rules. Ethical theories are bodies of principles and rules that are more or less systematically related (Beauchamp, 1989 p. 11).

Moral development has been extensively studied to determine how individuals progress cognitively in their ability to make ethical judgments and to reason morally throughout the life span.

Piaget began his study of moral development with the idea that morality is based on justice. He considers justice to be a concept that the rights of person stem from considerations of equality, social

contract, and reciprocity in human relations. Through interviews with children, he identified a model for the psychological analysis of moral judgment. Two major stages of moral development were defined; the first, morality of constraint and the latter morality of cooperation. Constraint and cooperation typically exist in the same child. The two stages are overlapping thought processes with the more mature gradually dominating the first. A morally mature child can, but does not necessarily, apply the principles of autonomous cooperation in his moral judgment (Likona, 1976, p. 220).

Kohlberg extended and refined Piaget's procedures and ideas. He used brief accounts of hypothetical moral dilemmas in interviews with subjects, identified many new characteristics of moral judgment and analyzed developmental progress toward universalized justice in terms of six stages of moral judgment. Kohlberg's findings show culturally universal stages of moral development. His theory, he claims, is both psychological and philosophical.

Table 1
Kohlberg's Developmental Stages

Preconventional

Stage 1 - Orientation to punishment, obedience and physical and material power. Rules are obeyed to avoid punishment.

Stage 2 - Naive instrumental hedonistic orientation. The child conforms to obtain rewards.

Conventional

Stage 3 - "Good boy" orientation designed to win approval and maintain expectations of one's immediate group. The child conforms to avoid disapproval. One earns approval by being "nice."

Stage 4 - Orientation to authority, law, and duty, to maintain a fixed order, whether social or religious. Right behavior consists of doing one's duty and abiding by the social order.

Postconventional

Stage 5 - Social contract orientation, in which duties are defined in terms of contract and the respect of others' rights. Emphasis is upon equality and mutual obligation within a democratic order. There is an awareness of relativism of personal values and the use of procedural rules in reaching consensus.

Stage 6 - The morality of individual principles of conscience that have logical comprehensiveness and universality. Rightness of acts is determined conscience in accord with ethical principles that appeal to comprehensiveness, universality, and consistency. These principles are not concrete (like the Ten Commandments), but general and abstract (like the Golden Rule).

The stage theory deals with what a subject thinks is right, and therefore, concerns what ought to be. It is not the content of the judgment that determines what stage a subject is at but the form of covert moral reasoning that had led him to the position he adopted. It is possible for six different subjects to make the same overt judgment about a moral dilemma while at the same time each being at a different stage from the others. In the U.S.. the dominant mode of moral reasoning is at Stage 4, equilibrium (Kohlberg, 1976, p. 31-35).

There is a tendency for a given stage to favor one specific alternative over another. Kohlberg holds that individuals at stages 4, 5, and 6 are more likely to be consistent in their behavioral patterns than those in lower stages. Persons at higher stages are governed by stable considerations based on objective standards or principles, while those at stages 1, 2, and 3 are governed by more personalized and situational factors, which are more readily subject to change. Therefore, it is predicted that persons at higher levels of development would present greater consistency and reliability of action. His findings generate a philosophy of moral education designed to stimulate moral development rather than teach fixed moral rules. Kohlberg believes

that a philosophic concept of morality and moral development is required, that moral development is stimulated by promoting thinking and problem-solving (Rich-Devitis, 1985, p. 92).

In addition to intellectual development, Kohlberg asserted that social and education climates are thought to be crucial; climates that provide opportunities for group participation, shared decision making, and assumption of responsibility for consequences of action stimulate moral judgment development (Kohlberg, 1971).

Kohlberg's research with children and young adults led him to believe that moral reasoning and cognitive thought are intimately related in a complex manner.

...since moral reasoning clearly is reasoning; advanced moral reasoning depends upon advanced logical reasoning; a person's logical stage puts a certain ceiling on the moral stage he can attain...While logical development is necessary for moral development and sets limits to it, most individuals are higher in logical stage than they are in moral stage (Rich, 1985).

Concern has been expressed that Kohlberg's studies have been done primarily with men and not adequate attention has been given to the concerns and experience of women in moral development. Women's identity is strongly dependent on relationships with others, and because of this focuses upon others, women were considered developmentally deficient in Kohlberg's theory. Gilligan contends that women's moral judgments differ from men's. For women the moral problem is defined in the context of exercising care and avoiding hurt. The infliction of hurt was seen as selfish and immoral while the expression of care was viewed as the fulfillment of responsibilities. Men have a perspective based upon justice, i.e. more concerned with issues of inequality and oppression and strongly values reciprocal rights and equal respect for persons (Chally, 1990, p. 304). The moral judgments of women differ from those

of men in the greater extent to which women's judgments are tied to feelings of empathy and compassion and are concerned more with the resolution of "real life" as opposed to hypothetical dilemmas. Gilligan (1977) postulates that,

The conflict between self and others... constitutes the central moral problem for women, posing a dilemma whose resolution requires a reconciliation between femininity and adulthood...the conflict between compassion and autonomy, between virtue and power - which the feminine voice struggles to resolve in its effort to reclaim the self and to solve the moral problem in such a way that no one gets hurt (p. 486).

At the third level, by elevating non-violence - the injunction against hurting - to a principle governing all moral judgment and action, women are able to assert a moral equality between self and other. Care then becomes a universal obligation, the self-chosen ethic of a post-conventional judgment that reconstructs the dilemma in a way that allows the assumption of responsibility for choice.

The moral issue which is expressed repeatedly in women's interviews is an injunction to care, a responsibility to discern and alleviate the "real" and recognizable trouble of the world. Women's insistence on care is at first self-critical rather than self-protective, while men initially conceive obligation to others negatively in terms of non-interference. Gilligan contends that for the women studied, the integration between rights and responsibilities appears to take place through a principled understanding of equity and reciprocity Gilligan (1977, p. 509).

Gilligan (1982) determined that both the perspective of care and justice were present when people faced real-life moral dilemmas, but people tend to focus on one set of concerns and only minimally present the other perspective. As expected, the care focus was more often exhibited by women, and the justice focus was more often exemplified by

men. A justice perspective is more concerned with issues of inequality and oppression and strongly values the ideal of reciprocal rights and equal respect for individuals. A care perspective is more concerned with issues of detachment or abandonment and strongly values the ideal of attention and response to need. The justice and care perspectives in themselves are not hierarchically ranked but are designated as two separate moral perspectives that organize thinking in different ways. The justice perspective strives to treat others fairly, while the care perspective endeavors not to turn away from someone in need (Chally, 1990, p. 305).

Influenced by the research of Piaget and Kohlberg, Rest (1986, p. 32) constructed a theoretical construct of stages of moral development and describes the elements for determining moral rights and responsibilities. Rest's instrument the Defining Issues Test (DIT) measures how individuals differentiate the crucial moral issues in a dilemma situation.

Rest suggests that moral judgment is one component among four in the production of moral behavior.

1. The person must have interpreted a social situation realizing that there is some action (or actions) that are possible for the person, and that each action has consequences for the welfare and interest of the parties involved. (moral sensitivity);
2. The person must have judged one course of action is the moral thing to do (this is the process that tests of moral judgment assess);
3. The person must decide to make the moral course of action his or her goal of behavior (moral motivation);
4. The person must have sufficient persistence, follow through and implementing strategies in order to actually carry out the goal of behavior morally (moral character) (Rest. 1986, p. 206).

Cognitive structure is seen as the framework by which affective

experiences are interpreted, and by which the strong, emotional experiences of today are translated into the commitments of tomorrow. Of interest to theorists in cognitive development are a person's basic problem-solving strategies and structural organization (Rest 1976), (Table 2).

Rest studied junior high school students through college students; seminarians; and, political science doctoral students. The study showed that 45% of the college students, 60% of the seminarians, and 93% of the doctoral students used principled thinking predominantly. Only 2.5% of the junior high school students used principled reasoning predominantly (Mayberry, 1986, p.76).

In another study conducted by Rest, he concluded that variables other than psychological (attitudinal) ones may exist to foster the development of moral reasoning. Adolescents who went to college changed twice as much in principled reasoning as did the non-college subjects. While both college and noncollege adolescents did not differ at first testing, and even though they maintained non-significantly different levels of comprehension regarding social and moral concepts, he concluded that despite the fact that they both advanced toward more principled reasoning levels, there was something in the college environment that facilitated the development of adolescents (Learner, 1986, p. 292).

TABLE 2
STAGES OF MORAL JUDGMENT (Rest, 1979)

Expectations about each other's actions are coordinated (how rules are knowable and sharable)	Schemes of social cooperation (how an equilibrium of interests is achieved).	Central concept for determining moral rights and responsibilities.
Stage 1 The caretaker makes known certain demands on the child's behavior.	The child does not share in making rules, but understands that obedience will bring freedom from punishment.	The morality of obedience: "Do what you're told."
Stage 2 Although each person is understood to have his own interests, an exchange of favors might be mutually decided upon.	If each party sees something to gain in an exchange, then both want to reciprocate.	The morality of instrumental egoism and simple exchange: "Let's make a deal."
Stage 3 Through reciprocal role taking, individuals attain mutual understanding about each other and the ongoing pattern of their interactions.	Friendship relationships establish a stabilizing and enduring scheme of cooperation. Each party anticipates the feelings, needs and wants of the other and acts in the other's welfare	The morality of personal concordance: "Be considerate, nice, and kind, and you'll get along with people."
Stage 4 All members of society know what is expected of them through public, institutionalized law.	Unless a society-wide system of cooperation is established and stabilized, no individual can really make a plan. Each person should follow the law and do his particular job, anticipating that other people will also fulfill their responsibilities.	The morality of law and duty to the social order: Everyone in Each society is obligated and protected by the law.
Stage 5 Formal procedures are institutionalized for the making of laws which one anticipates that people would accept.	Law making procedures are devised so that they reflect the general will of the people, but at the same time insuring certain basic rights to all. With each person having a say in the decision process, each will see that his interests are probabilistically being maximized while at the same time having a basis for making claims on other people.	The morality of societal consensus: "What laws people want to make is what ought to be."
Stage 6 The logical requirements of non-arbitrary cooperation among rational, equal, and impartial people are taken as ideal criteria for social organization which one anticipates rational people would accept.	A scheme of cooperation which negates or neutralizes all arbitrary distribution of rights and responsibilities is the most equilibrated, for such a system is maximizing the simultaneous benefit to each member such that any deviation from these rules would advantage some members at the expense of others.	The morality of non-arbitrary social cooperation: "How rational and impartial people would organize cooperation is moral."

Crisham, P. (1979). Moral Judgment in Nurses in Hypothetical and Nursing Dilemmas, University of Minnesota: Doctoral Dissertation, 109-110.

Chickering has described seven major dimensions of development during the college years: competence, emotions, autonomy, identity, interpersonal relationships, purpose and integrity (Rich, 1985, p. 91). In describing integrity, Chickering refers to the ability to organize values into internally consistent patterns to guide action, and the development of congruence between espoused values and conduct. This is an important aspect of value development, but not the only important one. Other important abilities are the capacities to think through one's values, to analyze and critically appraise them so that they may be either reformulated or else, if accepted largely unchanged, one could provide adequate grounds for doing so. Chickering cites residence halls and student-faculty interaction as having an especially important impact upon values (Rich, 1985, 97).

Social Learning Theories

Social learning theorists place special emphasis on the ways in which the environment impacts upon the individual. Moral orientations are considered to vary for different types of behavior and for the milieu in which that behavior takes place. Mature moral orientations are simple behavior, feeling, and cognition that are in conformity with those values of a social system that are evaluated positively by its members. In definition, a mature moral transaction is one in which (1) both known and unknown others are recipients without distinction for one's own positively evaluated behavior (one does not identify only with specific individuals or groups of individuals as legitimate recipients without distinction for one's own positively evaluated behavior); and (2) one's interaction with others will be such as to encourage them (by persuasion, modelling, etc.) to behave according to the same set of positively evaluated standards (Wilson, 1976, p. 121).

The social environment in which persons carry out their work can be an influence on the decision-making of an individual. Turiel (1983), in speaking of social knowledge and emotional development, suggests that,

At some times and in some situations it may indeed occur that the social system or institutional practices are in contradiction with moral practices. Assuming that individuals do form a core set of concepts of justice, welfare, and rights, such institutional practices may produce conditions for potential conflict. It should be kept in mind that the data have shown the coexistence of strong social organizational concerns and moral concerns (p. 226).

Social learning theorists dispute the notion of invariant development...they see moral orientations as varying for different types of behavior and for the milieu in which that behavior takes place (Wilson, 1976, 124).

Moral Reasoning and Moral Action

Although research has endeavored to describe the structural development of moral reasoning, there has been less concern with moral decision making. A person's reasoning gains genuine meaning in the context of making a decision. Several studies have found a relationship between moral reasoning and behavior of several kinds. Although research has demonstrated the relationship between moral reasoning and decision making, studies by Turiel (1983) have clarified the ways in which the relationship between moral reasoning and decision making changes according to stage of development. These studies showed that although Stage 4 subjects shifted their behavioral choice in response to a higher stage argument, which they preferred to their own modal stage, subjects at Stages 2 and 3 did not subordinate their behavior to more adequate and preferred arguments. Apparently, only Stage 4 subjects tended to integrate their moral choices with their moral reasoning (Weiss, 1982,

p. 852). Little in nursing education prepares nurses to perceive moral issues that arise in practice or make decisions in situations in which they must exercise moral judgment skills. In nursing situations that have no apparent clear-cut right or wrong solutions, nurses face typical moral dilemmas, that is, problems with two equally unacceptable alternatives. Nurses, therefore, regularly grapple with moral decisions. Planning of nursing education curricula and staff development programs depend on presently assumed, but untested, knowledge about nurse's ethical decision making (Crisham, 1980, p.110).

Kellmer (1984, p. 118-B) designed a study (1) to identify the personal and environmental factors which most influenced baccalaureate nursing students in their development of ethical decision making skills and, (2) to determine the whether implementation of a planned teaching program on ethics and its applications to nursing would influence the degree of importance accorded by baccalaureate prepared nurses to principled moral considerations in the making of moral decisions.

Selected conclusions from the study are:

1. Subjects (40) scored slightly above the mean for college students in the importance given to principled thinking in hypothetical moral situations using the DIT.
2. Subjects attained high scores in principled thinking in nursing moral situations using the NDT.
3. Personal and environmental variables most predictive of moral judgment levels were nursing grade point average and cumulative grade point average. Although nursing GPA was a positive predictor, cumulative GPA predicted negatively, that is, if the cumulative GPA was low, the moral judgment measure was high.
4. The variables of age, previous education, prior courses in moral philosophy and ethics and past work experience in health care settings have varying relationships with the dependent measures but were not strong predictors, and

5. There were no significant differences between the pre-test and post-test moral judgments of the experimental and control groups relative to the implementation of the planned teaching program.

Ethical decision making is highly probalistic in nature. Ethical decision making in nursing is further complicated by issues of bureaucracy, control, and power. Because of this ethical decision making engenders tremendous cognitive dissonance in nurses. When cognitive dissonance is intense the person may abstain from decision making completely.

Gaul (1987, p. 114) designed an ethics course to study the effect of the variables of ethical choice and ethical action in baccalaureate nursing students. The question posed was "Is there a significant relationship between ethical choice and ethical action in baccalaureate nursing students who have completed a nursing ethics course and those who have not?" Subjects consisted of 17 students enrolled in an ethics course and 20 students not enrolled in an ethics course. Ethical choice and action were measured by the Judgments about Nursing Decisions (JAND) instrument. The variables of moral choice and moral action were positively correlated ($r=.87(p<.001)$) in the students who were enrolled in the ethics course and negatively correlated ($r=-.32(p>.34)$) in the students who were not enrolled in the ethics course.

Gaul suggests that experience in the use of principled moral reasoning, founded upon ethical principles and theory, during the baccalaureate educational experience should enable the new graduate to approach ethical decision making in practice with increased confidence, increased accuracy and less cognitive dissonance.

The studies previously cited have emphasized moral reasoning in relation to moral development rather than moral behavior. Wilkinson

(1987, p. 27) studied the conceptual framework related to moral distress. Using 24 subjects who ranged in age from 25-58 with 3-30 years of experience, she examined the types of moral issues experienced by the nurses and their responses to them. The kinds of cases most frequently cited were: prolonging life, performing unnecessary tests and treatments (especially on terminally ill patients), lying to patients and incompetent and inadequate treatment by a physician. The cases described a variety of moral issues but the most frequently mentioned by the subjects were harm to the patient (in the form of pain and suffering) and treating persons as objects, i.e., dehumanizing them. The researcher concluded that moral distress does not automatically occur just because a certain case occurs. The nurse's belief system must be explored also. In instances of performing resuscitation, distress was dependent on the nurse's beliefs about the quality of life, killing and letting die, i.e., different nurses in similar instances would respond differently. The strength of the feelings is influenced by the degree to which the nurse identifies with the patient and by her/his perception of the nursing role in terms of rule-following versus active decision making. The nurse is influenced by the degree to which he/she feels responsible for what happens to the patient, and the degree to which he/she is able to say, "It is not my decision to make." Those nurses who are able to cope with moral distress and who leave bedside nursing seem to be those most aware of, and sensitive to moral issues, and who feel a strong sense of responsibility to patients and for their own actions (autonomy for patients and the nurse).

Wilson (1976, p. 128) believes that cognitive development is assumed to be one necessary but not sufficient condition for mature moral reasoning in the sense that such reasoning involves a developing

capacity to integrate information and to generalize from one concrete actual situation to many. Mature moral orientations cannot occur without cognitive development, but the existence of mature morality is not determined by cognitive development alone.

Learner (1986, p. 282) suggests that differences in moral reasoning level relate to contrasts in attitudes, personality and behavior. Principled thinkers see themselves as altruistic and idealistic. Their principled view of a person's relations to his or her social world provides a basis for active involvement in their world.

Research Related to Education in Moral Development

Bergman (1973, p. 152) suggests that ethical behavior can be "learned" because our ethical decisions derive from our cognitive processing in regard to problems we face.

Mustapha (1989) in a study which used Rest's DIT, moral reasoning levels were determined for freshman and senior undergraduates in a liberal arts program (traditional and integrated curriculum) and one nursing group (integrated curriculum). The study enrolled 266 male and female subjects. The liberal arts students in the integrated curriculum had significantly higher moral reasoning levels than those in the traditional curriculum. The nursing students were intermediate in moral reasoning levels to the two liberal arts groups. The conclusion was made that nursing educators should consider an integrated curriculum with a decision-making organizational structure to facilitate students' moral reasoning development. Her justification for this position is,

Regardless of their area of clinical practice, today's professional nurses are increasingly confronted with ethical dilemmas and often are required to make moral/ethical decisions. Nurses who reason at a high moral or ethical level are assumed to practice by a code of moral principles and thus are more likely to make decisions which value others

and respect their rights and dignity [autonomy] (p.107).

Keller (1985, p. 1870-B) using the Nursing Dilemma Test, surveyed a sample of 153 nurses. The questionnaire consists of six typical nursing situations. Subjects were to determine whether the dilemma was a moral dilemma and the extent to which they used moral and nonmoral reasons in resolving the dilemmas. Most nurses did not perceive the situations as dilemmas; of those who did perceive the dilemma situations as dilemmas, more than 90% selected at least one moral reason for their actions in the dilemma. Levels of education, and previous education in ethics were unrelated to nurses' abilities to identify a moral dilemma or to use moral reasons to justify their likely actions in a dilemma situation.

In a study which used a personal data survey, the DIT and the NDT, 40 second semester junior baccalaureate nursing students were pretested prior to enrollment in a course on ethical decision making. Post-testing five months following completion of the classes, the data revealed:

1. Scores slightly above the mean for college students in principled reasoning in hypothetical moral situations.
2. High scores in principled thinking in nursing moral situations supporting the findings of Crisham.
3. Variables predictive of moral judgment levels were nursing GPA, predicting positively and cumulative GPA predicting negatively.
4. There were no significant differences between pre-test and post-test moral judgment scores relative to the planned teaching program. (Kellmer, 1984, p. 132-3).

In a study of community health nurses and their responses to ethical dilemmas, no one identified an ethics course as a guide to their decision making even though more than half claimed to have had such a

course (Aroskar, 1989, p. 968)

Rest (1976, p. 160) has indicated that principled moral reasoning is highly correlated with education and adults do not demonstrate much advance in moral reasoning beyond that correlated with their level of education.

Murphy (1976) measured moral reasoning levels of nurses who held different positions of authority in hospital and public health practice settings. While type of education was not one of her variables, she found no significant differences between her two groups; only 5% of her sample (120 nurses) used stage 5 as their modal stage of moral reasoning. She contends that,

...to function optimally and independently in a complex milieu and to act as responsible and accountable moral agents, nurses need to have attained a postconventional level of morality and that conventional morality is dysfunctional. (p. 593-B)

There were no overall differences in levels of moral reasoning among nurses working in different types of environments and positions of authority.

In her doctoral dissertation, Awtrey (1980) explored whether baccalaureate nursing student's preference for principled reasoning over conventional or preconventional reasoning changed as they progressed in their educational program. She postulated that experiences in confronting moral dilemmas would be a factor affecting moral development. The assumptions were that one of the aims of education is the fostering of moral growth and development, that students have the potential for growth and educators have opportunities to provide an environment for moral growth. The nursing student sample possessed about the same amount of principled reasoning as did other college students. After a two year period, there was no indication that the nursing

students studied were gaining the conceptual tools necessary for resolving the moral dilemmas recurring in contemporary health care situations.

Ketefian (1981, p. 175) using the Judgments about Nursing Decisions (JAND) found that when groups were examined in terms of differences in personal and professional variables, such as education, experience, work setting, area of practice or position, the only noteworthy findings related to education. She also found, however, that nurses do not sustain their level of moral development within the context of the work setting.

Gaul (1986, 4113-B) raised the question "What is the relationship between practicing nurses' level of moral reasoning and ethical decision making in nursing practice?" Using a sample of 132 practicing registered nurses, she found that the principled reasoning score was 39% This means that 61% of the nurses reasoned at the conventional level or less. She concluded that the level of moral reasoning of practicing registered nurses is predominantly concerned with issues of reward and punishment and with preserving the existing power structure. She believes that registered nurses know the correct ethical decision but pragmatically they may not choose it.

In a study designed to determine the relationship between moral reasoning and moral action, Turner (1984, p. 2026-B) presented simulated dilemma nursing situations in which the nurse could: (1) do nothing; (2) provide indirect assistance to an individual in need of help; or (3) provide direct personal assistance to a person in need of help. Subjects then responded to an open-ended interview and completed the Kohlberg moral judgment interview. Findings indicated significant relationships between nurses' stage of moral reasoning and the degree of

assistance they provided. There was also a significant relationship between the measured stage of moral reasoning and the consistency between what subjects believed they should do and what they were observed to do.

Zablow (1984, 2501-B) raised the question of "What is the nature of the moral dimension of professional nursing practice?." One-hundred and fifty nurses were asked to identify a moral situation they had encountered in nursing practice. Analysis of the data disclosed that the moral dimension of nursing practice is a domain of great personal indecision and uncertainty. Often, what the nurse cited as a moral situation was merely a difference of opinion and did not possess clearly identified elements of moral concern. Frequently, even when the situation was clearly a moral situation, the nurse had difficulty identifying the moral elements inherent in the situation and in choosing an appropriate course of action.

There is strong concurrence in the literature concerning ethical decision making. Ethical decision making needs to be anticipatory. The nurse needs a background based upon knowledge of ethical principles to ensure that actions conform to recognized ethical interventions. Gaul (1987, p. 116) suggests that experience in the use of principled moral reasoning, founded upon ethical principles and theory, during the baccalaureate educational experience should enable the new graduate to approach ethical decision making in practice with increased confidence, increased accuracy and less cognitive dissonance.

The Influence of Practical Considerations in Moral Reasoning

The cognitive process of defining an issue as a moral one and assessing the probable problems that may arise in trying to intervene in

a situation has been called practical considerations in the NDT. During the decision making process thoughts such as, "Will I have to involve the physician?"; "Will my administrator or supervisor support my actions?"; "Do I have the time that will be necessary to make a difference in this situation"; or, "Will I be in violation of any of the procedures or expectations of this agency?" Crisham verified the significance of formal education and previous involvement with similar dilemmas in enhancing principled thinking and raised questions about the relative strength of practical considerations in the hospital milieu.

Rest (1986, p. 17) deals with the issue of practical considerations by stating that,

As the costs of moral action come to be recognized, a person may distort the feelings of obligation by denying the need to act, denying personal responsibility or appraising the situation to make alternative actions more appropriate. In other words, as subjects recognize the implications...and the personal costs of moral action become clear, they defensively reappraise and alter their interpretation of the situation.

The reality is that professional dilemmas often are a mix of technical and moral issues. Usually a person's professional education will focus upon the technical aspects of the profession. The student becomes conditioned not to recognize and deal with the moral issues of the job. Without intending to do so, professional schooling overemphasize the technical so as to blind the professional to the moral issues (Rest, 1986).

Omery (1985, p. 103) studied the moral reasoning of nurses who work in the adult intensive care setting in order to identify the composition of moral reasoning used by nurses when faced with a moral dilemma in their practice. Interviews were conducted with 10 nurses using open-ended questions. It was concluded that moral reasoning had

three major characteristics: (1) principles which are generalizations that provided justification for the moral decision and the direction for the moral action; (2) mediating factors which were specific conditions that either compelled or restrained the reasoner in their decision to use a particular principle, e.g. the situation, legal constraints and/or the nurse physician relationship; and (3) modes of reasoning: (a) accommodating reasoners adapted their reasoning to conform with the norm of their group, (b) sovereign reasoners based their judgments on self-chosen and valued moral principles.

Research Related to Job Factors in Nursing

Murphy (1977, p. 87) proposes four models: (1) patient advocate; (2) nurse-patient; (3) bureaucratic and (4) physician advocate. In the bureaucratic model, the goal is to maintain the social order of the institution at the expense of the individual patient's welfare. Emphasis is on teamwork and team responsibility with no consideration of the nurse-patient relationship and accountability. Of the four only the patient advocate model is based upon post-conventional criteria where social contract and universal ethical principles form the basis for action. Pinch (1985) proposes that:

At foundation of the ideal professional role is the characteristic of autonomy which enables the nurse to promote patient rights as she relates to the patient in a patient advocate role (p. 373).

Certain conditions stimulate higher levels of moral development. An environment that offers opportunities for group participation, shared decision-making processes, and responsibility for the consequences of actions promote higher levels of reasoning (Chally, 1990, p. 303).

Job satisfaction/dissatisfaction in nursing has been studied by many researchers. A longitudinal study of hospital nurses job

satisfaction and turnover revealed that staff nurses viewed autonomy as the important factor in job satisfaction (Alexander, 1982, p.49). In studying the job satisfaction/dissatisfaction, Hall (1981), used a questionnaire with one hundred and eighty-five nurses enrolled in the study. Findings revealed the longer nurses were employed, the less likely they were to be satisfied with tasks requirement and their autonomy

In a study which investigated the effects of moral reasoning and the work environment on moral behavior of registered professional nurses, a significant relationship was found between moral reasoning and moral behavior while controlling for reading comprehension in the group of white nurses ($n=35$; $p<.02$). A significant relationship between supervisor support and moral behavior ($r=.32$, $p<=.03$) was also found in this group. A statistically significant, though trivial, negative relationship was found between moral reasoning and moral behavior for nurses born outside of the U.S. ($n=84$, $r=-.19$, $p<.04$)(Nokes, 1985).

Arbeiter (1984, p. 38) in a study on the reasons why R.N.'s left the traditional hospital setting to work in a home health care agency were:

1. no double shifts or shift rotation,
2. the emphasis on holistic, primary nursing care in home health settings,
3. professional versatility and autonomy,
4. community involvement, and
5. competitive salaries and fringe benefits with hospital-based nurses.

In the same study, administrators of home health agencies reported that the following characteristics were an essential part of the home health nurse: self-reliance, flexibility, adaptability, confidence,

versatility and empathy.

Curreri (1985, p. 135) studied job satisfaction among hospital and home health agency nurses. Of the 157 nurses enrolled in the study (84 home health care; 73 in hospitals). The statistical hypothesis was "There will be no difference between registered nurses working in the traditional hospital setting and registered nurses employed in the home health care industry with regard to their level of satisfaction." Satisfaction levels were defined as perfect dissatisfaction, neutral satisfaction, and perfect satisfaction. Looking at the groups overall, it was concluded that neither group was satisfied with their jobs. The home health nurses were significantly more satisfied than the hospital nurses with regard to involvement satisfaction and intrinsic satisfaction. Home health care nurses identified satisfiers as:

1. opportunities to use their skills,
2. participation in important and worthwhile activities,
3. their overall feelings of self-fulfillment.
4. opportunities to direct others connected with their jobs,
5. sharing in the determination of methods and procedures connected to their jobs, and
6. opportunities to share in the setting of organizational goals.

Aroskar (1989, pp. 968-69) collected data in a descriptive study which focused exclusively on ethical problems in community health nursing. She examined how nurses deal with issues in their everyday practice. Individual respondents were asked to identify the single most significant ethical problem they deal with in their practice, the ethical principles and values at stake, and the types of resources used to deal with the problem. Ethical problems were defined as those problems in which there is a conflict about the morally right action to

take or in which the duties and obligations of professionals are unclear. The first example is the value of preventing or minimizing harm (principle of nonmaleficence) while doing good to or benefiting the patient (principle of beneficence) collides with respecting individual client autonomy, the autonomy of families, or the nurse's autonomy.

Examples given were:

1. Keeping a dying patient alive against his will.
2. A terminally ill patient using narcotics when the nurse does not feel it is necessary.
3. An alcoholic husband caring for a wife with Alzheimer's disease is incapable of his own decisions and leaves wife alone.

A second category related to truth telling. One example related to family members distrust of the nurse when she is telling the truth. Another problem is encountered when the physician and family members did not tell the client that he/she has terminal cancer.

A professional problem which is increasing, is not betraying questionable quality of practice of some nurses and physicians when the client's welfare is at stake. Of particular concern in today's society, is the chemically impaired nurse and the possible effects upon patient care.

A fourth category identified by the nurses was that of distributive justice. The problems which involve justice are concerned with termination of care for individuals when reimbursement is no longer available, lack of agency funds and nursing staff to provide quality care and the struggle to provide equal medical care regardless of race or finances.

In discussing the resources that nurses used to deal with ethical problems, no one identified an ethics course as a guide even though more than half had claimed to have taken a course in ethics. Community health

nurses turned to colleagues for assistance. They also used supervisors, administrators, friends, and family as resource people.

The most significant ethical problems described by the nurses focused on the individual client and advocacy for that individual. Families were considered to contribute to the client's difficulties. There was little sense of family or the community as client even though half of the nurses were baccalaureate prepared.

Research Related to Nurse and Patient Autonomy

One criterion of moral maturity - autonomy of judgment (the ability to make up one's own mind about what is right and wrong) is not present in the preconventional and conventional levels of reasoning. If a person does what he is told to do because of fear of authority (Stage 1); because it brings pleasure (Stage 2); because it is expected behavior (Stage 3); or because it is law (Stage 4), he has never really made moral decisions. Moral maturity is the ability to make moral judgments rather than conform to the moral judgments of others (Krawczyk, 1978, p. 254).

In the Code for Nurses, the principle of autonomy is contained in the statements,

1. The nurse provides services with respect for human dignity and uniqueness of the client,
2. Each client has the moral right to determine what will be done with his/her person, and
3. The nurse's respect for the worth and dignity of the individual human being applies irrespective of the nature of the health problem (Fry, 1983, p. 177).

The principle of respect for personal autonomy is one among several important moral principles in bioethics. Childress (1990) indicates that,

Respect is more than attitude, it is an act of refraining from,

interfering with, or attempting to interfere with the autonomous choices and actions of others, through subjecting them to controlling influence, usually coercion or manipulation of information. ...In health care, it engenders a positive and affirmative obligation to disclose information and foster autonomous decision making (p. 12).

Autonomy of patients is a complex concept. In order to respect a person's choice the professional needs to know what preferences he/she is expressing. The complexity is further increased because people express their choices through signed consent, through their words and their behavior. In addition, the patient himself may be experiencing ambiguity about the possible choices and their effects (Childress, 1990, p. 14).

In the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, a survey was taken regarding decision making in health care. Seventy-two percent of the people surveyed wished to make decisions jointly with their physicians. In the same survey, 88% of the physicians responding indicated that patients want doctors to make decisions for them. This wide disparity indicates that self-determination for patients is at high risk in most health care contexts and that there is low recognition among physicians (and possibly among other health care workers) of the high value patients place on autonomy (Spradley, 1985, p. 19-20).

Consumers are demanding greater control over their own destiny, greater input into decisions that influence them and greater rights to satisfaction. Reassurances that "doctor [nurse] knows best" no longer suffice (Butler, 1979, p. 101).

Braden (1976, p. 444) contends that increased awareness of patients' rights to make decisions about their own care has hastened the growth of the nurse's patient-advocate role. Nurses need to assist the

growth of patients autonomy and integrity by opposing interference, untimely interventions, premature labeling, lack of involvement and lack of individualization. True acceptance of patient autonomy is based on the ability to distinguish what a nurse is responsible for from what the patient owns.

Using the DIT, Munhall (1980, p. 60) raised the questions: "From what moral conceptual frameworks do nursing students and faculty enter into this experience?"; and "Do nursing students develop an increase in moral consciousness and does their internal thought structures make feasible acquisition of roles as patient advocates, change agents and risk takers?" Her sample consisted of 76 freshmen, 60 sophomores, 81 juniors, 88 seniors and 15 faculty members. The nursing freshmen were used as a baseline since their theoretical and clinical content does not begin until their sophomore year. An analysis of grade point average revealed a significant difference for distribution of higher levels of moral reasoning with higher grade point averages. There were no significant differences among all groups on the variables of age, economic level, parents' occupation, previous nursing experience, extent of religiosity, perception of moral integration and specific educational characteristics. Munhall concludes that in a system where the patient, as well as the nurse, is virtually powerless and where both undergo dehumanization in the process, the likelihood of increasing moral reasoning is small. There may be little encouragement for those individuals who question authority, press for change or wish to practice autonomously. There is a need for evaluation of the moral climate of the institution and the extent to which nurses (other than administrators) share in decision making for patient outcomes.

In examining the extent to which moral reasoning and perceptions

of autonomy contributed to explaining moral judgment when intelligence was controlled deJong (1985, p. 792-B) that moral reasoning was not significantly related to ethical judgment. Nurses who perceived themselves as having autonomy at work, believed that nurses in dilemmas would make ethical decisions.

In a study which focused on the views of nurses regarding dependence versus independence for both nurses and patients, the authors focused on three constructs: (1) nursing autonomy, (2) patient's rights, and (3) rejection of traditional role limitations (nurses). The study included 702 subjects in hospital settings. The rejection of traditional role limitations was defined as the nurse's perception of how much latitude nurses have, are allowed, or would be willing to take in functioning as a responsible professional. Nurses with advanced preparation were determined to be stronger supporters of the autonomous role. The community hospitals in the study tended to be the most traditional with over 90% of the nurses prepared at the diploma level. In the psychiatric hospital (which was associated with a university), the nurses had more open attitudes than those in the traditional setting. The nursing leaders in the psychiatric setting held masters or a doctorate degree and had by far the most progressive attitudes regarding nursing autonomy and patient's rights (Pankratz, 1974, p. 215).

Dennis (1990, p. 162) in a study which was a replication and extension of research on the types of activities which contribute to patient's sense of control during hospitalization, confirmed four types of patient control orientations:

1. patient role fulfillment,
2. health care decision making,

3. personal integrity preservation, and
4. global determination.

The finding was that in all of these categories, having information was essential. The author concludes that information flow should be a high priority for all personnel whom patients encounter throughout the course of hospitalization and that as patient advocates and coordinators of care, nurses can relate and reinforce the importance patients attach to having information about their disease, care, and treatment and can encourage everyone to keep patients informed.

Pinch (1985, p. 372) studied decision making in ethical dilemmas and attitudes toward professional autonomy. The assumption is made that autonomy is necessary for patient advocacy (as described by Murphy's patient advocate model). In this advocate model,

The nurse considers her moral authority to be as great as any other health professionals and sees her first responsibility to and for the patient as a unique human being...to help facilitate the patient's efforts to obtain whatever care is needed, even if it means going against the doctor or the hospital administration (Murphy, 1976, p. 593-B).

In the study which included 294 participants, most of whom were female, caucasian and attending a Roman Catholic private school, nurses selecting the patient advocate model was the first choice of interaction chosen by senior (84%) and graduate level students (86%), while 51.4% of the freshman ranked the model as a first choice (chi-square 42.5, df=4, $p < .01$). The freshman would exhibit an orientation to maintaining rules and authority, keep the system going, and support the physician in his relationship with the patient. These behaviors are considered to occur at a conventional level of moral reasoning.

Pinch (1985, p. 37) indicates that behaviors in the clinical

setting have not been monitored, thereby, the correlation between intellectual belief and real action is not known. There is indication that graduates do increase a little in autonomy (1.6%) and in support of the patient advocate model (2.0%). Pinch feels that this shift and continued change is important and shows the presence of attitudes and an intellectual foundation that can be built upon in continuing education experiences.

Wilberding (1984, p. 72) in a qualitative, descriptive study investigated nurses' concepts of patient advocacy and how they operationalize these in practice by interviewing 15 hospital staff nurses. Influences reported by the nurses were:

1. nursing education is a source of belief in patient advocacy as a role for nurses,
2. observing practices which are contrary to personal beliefs may lead the nurse to believe in advocacy as a need for the patient. (Example: a patient signing a consent form when he/she is not aware of the consequences.),
3. the nurse's belief that she is central to the patients care. (Nurses spend more time with patients and they bring together everything for the patient).

The process of becoming an advocate is a continuing one. It may take years of experience as the nurse becomes aware of more options for the patient. Experiences as a patient advocate in nursing practice increase the nurse's confidence and comfort with their role. Positive feedback from patients as the nurse practices advocacy reinforces the role. Wilberding (1984, p. 71) identified three major phases in assuming the role of advocate:

1. Coming to believe in advocacy as a nursing role,
2. Learning about advocacy as a nursing student, and
3. Functioning as a patient advocate over a period of years after graduation from nursing school.

Weisman (1981, p. 442) in studying perceived autonomy among nurses in a hospital setting, found that head nurses who were perceived as responsive to staff nurse needs were associated with high levels of autonomy. It is unknown whether these head nurses foster feelings of independence among their staff or whether nurses who perceive themselves to be autonomous tend to report more favorable attitudes toward their head nurses. Further study needs to be undertaken in this area to determine what if any relationship is evident.

In a study which included 45 community health nurses with baccalaureate nursing degrees, senior-level generic nursing students, and registered nurses in a baccalaureate nursing program, comparisons were made on age, education, places of employment in nursing, and three variables of professional autonomy: nurses' rights and responsibilities, the nurse-patient relationship, and nurses' role in health care delivery. It was predicted that nurses from baccalaureate programs and those practicing in community health nursing would perceive themselves as more autonomous and that age and years of employment in nursing would not appreciably alter their perceptions of autonomy. An analysis of variance confirmed the initial prediction at the 0.01 level of significance or better for nurses' rights and responsibilities and their role in health care delivery. A significant negative correlation was obtained between years of work experience and nurses' rights and responsibilities for only the registered nurses. Wood (1986) concludes that,

The question is not only how much freedom nurses see for themselves, but how much they allow their patients. It is assumed that nurses can be more valuable to patients as they use their autonomous role to become patient advocates.

The regard to the mean scores on the patients' rights dimension, the emphasis placed in community health nursing on patient

advocacy requires consideration. Community health nurses are frequently required to intervene on behalf of patients, to assist clients in identifying health care alternatives, and to promote selection of alternatives most aligned with the patient's values and beliefs. Since there was no statistical significant difference between community health nurses and student nurses, we can only speculate that baccalaureate education may promote stronger beliefs about patients' rights than alternative programs. We also suggest that the practice setting may be a major factor affecting nurses' beliefs about patients' rights (p. 131).

DeJong (1985, p. 792-B) in examining the extent to which moral reasoning and perceptions of autonomy contributed to explaining moral judgment when intelligence was controlled, found that moral reasoning was not significantly related to ethical judgment, and nurses who perceived themselves as having autonomy at work, believed that nurses in dilemmas would make ethical decisions.

Job satisfaction/dissatisfaction in nursing has been studied by many researchers. A longitudinal study of hospital nurses job satisfaction and turnover revealed that staff nurses viewed autonomy as the important factor in job satisfaction (Alexander, 1982, p.51). Two hundred and eighty-five nurses in responding to a questionnaire on job satisfaction found that the longer nurses were employed, the less likely they were to be satisfied with task requirements and their autonomy (Hall, 1981, p. 33).

Summary

Extensive studies have been carried out in the area of moral development by Kohlberg, Rest and others. The findings of these studies suggest the following:

1. Empathy is a very early acquisition. People feel bad when they see someone in distress.
2. A caring and mutually supportive relationship with another person is one of the primary goods that humans value.

3. As the individual personality system develops, involving the development of self-concept, people generally want to think of themselves as basically decent, fair, and moral.
4. The development of individual identity as a moral person carries at least part of the motivation to be moral.
5. It has been found useful to approach the complexity of morality by posing the question: When a person is behaving morally, what must we suppose has happened psychologically to produce that behavior? Logically we would claim that the person must have performed at least four basic psychological processes. The person must have:
 - a. made some type of interpretation of the situation in terms of what actions were possible, who (including oneself) would be affected by each course of action, and how the interested parties would regard such effects on their welfare.
 - b. been able to make a judgment about which course of action was morally right, thus labeling one possible line of action as what a person ought to do in that situation.
 - c. given priority to moral values above other personal values such that a that a decision is made to intend to do what is morally right, and
 - d. sufficient perseverance, ego strength, and implementation skills to be able to follow through on his/her intention to behave morally, to withstand fatigue and flagging will, and to overcome obstacles (Rest, 1986, p. 18-19).

Baly (1984, p. 111) indicates that the individual has to decide what is the right thing to do. If the right questions are asked there is a greater likelihood that the decision will be 'right.' Moral philosophy has not supplied answers but it has suggested some of the questions.

Ketefian (1981, p. 175) using JAND in studying the relationship between critical thinking and moral reasoning found that nurses primarily are at stage V which reflects social contract and legalities; being able to think critically enhances moral reasoning; and that nurses with advanced education have increased levels of reasoning over that of

technically prepared nurses. In addition, while nurses are engaged in a program of study, they experience changes in their role conception and professional socialization but these changes are not sustained within the work setting.

If nurses are unable to recognize the moral dilemmas within their practice, or once having recognized a dilemma are unable to make a judgment about the appropriate action based upon ethical principles, such as, beneficence, nonmaleficence, or respect for persons and their inherent worth and dignity, they will be unable to function as an advocate in their practice. For some nurses the work environment can be a deterring effect in fulfilling the advocacy role due to the practical concerns of meeting the expectations of the employing agency or supervisors. A further deterrent is that even for the nurse who understands and wants to practice as an advocate, if there is no support from co-workers, administration or continued educational opportunity, over time the desire to function in the role will diminish.

Chapter 3

RESEARCH DESIGN

This study is descriptive in design. In this chapter the purpose, hypotheses, and design of the study will be presented. Procedures for the selection of subjects, data collection, and analyses of data will be described.

Purposes and Hypotheses of the Study

There are two specific purposes in this research study. The first purpose is to raise the question "What is the relationship between ethical/moral judgment and selected demographic characteristics of the nurse. The second purpose is to determine the relationship between the nurse's level of ethical reasoning as evidenced in Nursing Principled (NP) scores and those factors which influence the nurse's ability to act as an advocate, specifically autonomy (both nurse and patient) and agency support.

In addressing the first purpose, certain research questions are raised which are stated as null hypotheses (H_0):

H_{01} = There is no significant relationship between ethical judgment scores and age.

H_{02} = There is no significant relationship between ethical judgment scores and the educational preparation of the nurse (baccalaureate, associate degree or diploma).

H_{03} = There is no significant relationship between ethical judgment scores and number of years employed in nursing.

H_{04} = There is no significant relationship between ethical judgment scores and place of employment (health department, home health care or hospice).

H_{05} = There is no significant relationship between ethical

judgment scores and the length of time employed in a community nursing agency.

H₀₆ = There is no significant relationship between ethical judgment scores and instruction in ethical principles and practices (i.e., course in ethics, part of a course, or part of a clinical experience).

H₀₇ = There is no significant relationship between ethical judgment scores and amount of continuing education (workshops, staff development or conferences).

The second purpose raises the following research questions which are stated as null hypotheses:

H₀₈ = There is no significant relationship between nurses' beliefs about patient autonomy and ethical judgment scores.

H₀₉ = There is no significant relationship between the nurse's perception of his/her autonomy in decision making and ethical judgment scores.

H₀₁₀ = There is no significant relationship between the nurses' perception of agency support and ethical judgment scores.

H₀₁₁ = There is no significant relationship between nursing principled reasoning and practical considerations.

H₀₁₂ = There is no significant relationships between principled reasoning and familiarity with the dilemma.

Design of the Study

Methodology

This study used three instruments to collect data:

1. Personal Data Sheet (PDS) (See Appendix A)
2. Nursing Dilemma Test, (NDT) (See Appendix B), and

3. Nursing Advocacy Beliefs and Practices (NABP)

Questionnaire (See Appendix C).

The PDS requests demographic information from the respondents such as age, sex, basic education, work experience, current position (i.e., public health agency, home health agency or hospice), length of time in the position, and any previous teaching regarding ethics in their educational experience or in continuing education or workshops.

The NDT (Appendix B) consists of 6 recurrent nursing dilemmas that represent moral issues and clinical areas of nursing. There are three tasks for each of the six dilemmas:

1. Deciding what the nurse should do.
2. Ranking the moral and practical considerations in order of importance, and
3. Indicating the degree of previous involvement with a similar dilemma.

The NDT was designed by Crisham using Rest's (1974) Defining Issues Test, (DIT) which is based upon the six Kohlberg stages of moral development. The DIT measures moral reasoning in hypothetical situations while the dilemmas in the NDT differ in that they are situations which actually recur in nursing practice (Mitchell, 1977). Crisham (1979) has reported a statistically significant positive correlation between the DIT and the NDT ($p < 0.001$) but the correlation magnitude was not provided. A coefficient of 0.57 was reported for principled reasoning in nursing situations. Crisham (1979) suggests that the dilemmas in the NDT may be different from those measured in the DIT in the following ways:

1. They are not hypothetical and recur in nursing practice as actual moral problems.

2. They have specific characteristics in terms of their content area and demands.
3. They are familiar in varying degrees to staff nurses.
4. They involve numerous practical issues such as time allotment, health team availability, and physical structure of the setting.

The NDT is a copyrighted instrument and permission was obtained from Patricia Crisham at the University of Minnesota (Appendix B) to use the instrument in this study. In scoring the NDT, measurements are made of nursing principled judgments which represent Stage 1 scores (2 per dilemma), a practical consideration score (1 per dilemma), 2, 3, and 4 stage scores (3 per dilemma) and a familiarity score (F score) which measures the extent to which subjects have been involved in a similar dilemma or known someone who has been involved in a similar dilemma. The F score allows for analysis of moral judgment against a backdrop of previous knowledge of situations similar to those depicted. The practical consideration score (PC) indexes the relative importance given to practical considerations in making decisions on moral issues. The Nursing Principled (NP) score is calculated by adding the sum of weighted ranks given to principled items and is interpreted as the relative importance given to principled moral considerations in making a nursing moral decision. The highest possible NP score is 66 with 2 NP items for each dilemma. The relative importance given to practical considerations was indexed in a similar process. The PC was calculated by adding the scores of items that represented Practical Considerations and across the six dilemmas. The PC index represents the sum of weighted ranks given to Practical Considerations in making a moral decision. The highest possible PC score is 36 with 1 PC item for each dilemma.

Additionally, Dr. Crisham suggested that scores could be obtained for Stage 2, 3 and 4 which represents the subject's level of reasoning and a score for the subject's action choice in Part A of the test.

In measuring the subject's degree of previous involvement with a similar dilemma, a Likert-type scale was used. This familiarity score was calculated by adding the points that indicated the subject's degree of previous involvement with similar dilemmas across the six dilemmas. The F index represents the sum of the subject's indication of degree of familiarity with similar dilemmas. A score of 6-17 represents familiarity with dilemmas and a score of 18-30 indicated unfamiliar with dilemmas. (Appendix B)

The Nursing Advocacy\Beliefs and Practices Questionnaire (NABP) (Appendix C) was developed for this study and measures the relationship between the ethical development of the nurse (NDT scores) and the strength of the nurse's beliefs about patient autonomy, nurse autonomy and organizational support. To establish construct validity, two nursing professors and one public health nursing supervisor were asked to review the 28 questions and indicate whether the statement reflected the construct of patient autonomy, nurse autonomy or organizational support. This review was conducted independently of each other and agreement was obtained on 25 of the 28 items. On one item two reviewers had agreement and the item was retained, while one question was reworded to provide greater clarity, and one question was deleted and replaced with a question which reflected organizational support.

A trial run of the PDS and NABP instrument was conducted with four public health nurses from an agency not selected for inclusion in the study.

The purpose of this trial study was to:

1. Determine the amount of time required to supply the requested information.
2. Ensure that questions were clear and unambiguous, and
3. To review the items for consistency between subjects.

The results of the pilot run revealed that the average time for the completion of the two instruments was 12.5 minutes with a range from 5-30 minutes. The nurse that took the longest to complete the questionnaire seemed unable to interpret many of the questions as formulated. The remaining 3 reviewers made no further suggestions. Only 10 responses out of 112 were recorded in the "undecided" column. Scores for this instrument would range from 28 for strongly agree to 140 for strongly disagree. There are 8 items related to patient autonomy; 12 items related to nurse autonomy and 8 items related to organizational support on the NABP. A Spearman-Brown split halves analysis was done to determine reliability. On the nursing autonomy items a reliability of .7430 was obtained (Guttman Split Half .7429); on the patient autonomy items a reliability of .7412 was reported (Guttman .7312) and on the organizational support a reliability correlation of .7621 (Guttman .7436).

Table 3 presents the predictor variables and a description of the instruments as they relate to the study.

Study Population

The sample population of agencies was selected randomly from a list of public health, home health, and hospice agencies in the one state in the mid-West. Nursing administrators were asked to participate in this study by providing a list of full time registered nurses (R.N.'s) and agreeing that the individuals would be encouraged to participate if selected.

Table 3

PREDICTOR VARIABLES AND INSTRUMENTS

PREDICTOR VARIABLES	SOURCE	DEFINITION	# OF ITEMS
AGE		Age in years	1
SEX	Demographic Data	Male/female	2
BASIC EDUCATION	(Instrument I)	Diploma School, Associate Degree in Nursing, Baccalaureate Degree in Nursing, Other degrees: Nursing or Non-nursing degrees	4
WORK EXPERIENCE		In months or years	1
CURRENT POSITION		Public health nursing, Home Health Care, Hospice Care	3
LENGTH OF TIME IN POSITION		Months or years	1
ETHICS TEACHING		In a course during educational experience; part of a course; part of a clinical experience.	3
OTHER ETHICAL LEARNINGS		Continuing education; workshop or conferences; name of offering.	2
PRINCIPLED REASONING	Nursing Dilemma Test	Nursing principled scores are those judged to be reflective of moral judgment in real-life nursing dilemmas.	12
PRACTICAL CONSIDERATIONS	(Instrument II)	Practical consideration scores indicate issues which influences nurses' decision-making, such as time, and what help is available in making a decision.	6
FAMILIARITY WITH SITUATION		The sum of the subject's degree of involvement with a similar ethical dilemma.	5
II. PATIENT AUTONOMY	Nursing Advocacy/ Beliefs & Practices	Patient choices about their care; i.e., the degree to which the patient rights are respected.	10
NURSE AUTONOMY		The degree to which the nurse assumes responsibility for ethical professional practice.	10
ORGANIZATIONAL SUPPORT	(Instrument III)	The degree to which the nurse perceives support for ethical practice by agency administrators.	8

Using the employee lists, subjects were assigned random numbers by computer and 80 individuals were selected from health departments; 80 from home health care and 40 from hospices to secure a population of 200 individuals. Individuals were drawn from 7 health departments (80 individuals); 10 home care agencies (80 individuals) and 12 hospices (40 individuals).

A sample of the letters sent to administrators and possible participants are in Appendices E & F. Due to a steady return a second requests was not made until a month had elapsed.

The returns from health departments came without the need for a reminder. Reminders were sent to home health agencies and hospices. The approach to hospices was delayed because many of the hospices were unable to provide subjects since their staff did not meet the full time requirement, so more agencies than previously anticipated were approached to secure full time employees.

During the process of approaching agencies to participate in the study, a telephone call was received from a professor at another university. She had learned about this study from one of the agencies that they had approached which shared the information that there was another study being done on ethical issues. The content of the telephone call was a description of the study that the university was undertaking. There were to be 1500 community health subjects in the study (including disciplines other than nursing). The intent was to have the participants describe the type of ethical dilemmas they experienced in their practice and the strategies they used to deal with them. The professor also asked if this would create a problem in regard to this dissertation and offered to delay their mailing of instruments if necessary.

Since the mailing of the letters to administrators had already

been done in this study and the instruments were being mailed upon the receipt of the staff member's names, it was mutually concluded that there would probably be no conflict between the two studies.

Subsequently, only one hospice administrator mentioned the existence of the university study, so the assumption was made that the university study did not have an impact upon the agencies in which subjects were drawn for this study.

Data Collection

An application was submitted to the University Committee on Research Involving Human Subjects. The request was for confidentiality rather than anonymity so subjects could be contacted if their instruments were not returned. The project was approved by the committee which advised that the rights and welfare of the humans subjects appeared to be adequately protected.

The study was conducted by mail and the cover letter to agency administrators included (Appendix E):

1. Name and address of the researcher.
2. The purpose of the study.
3. Approximate length of time required to complete the material.
4. A statement regarding confidentiality.
5. A statement which includes all requirements to be met in the use of human subjects in studies.
6. A statement that a brief summary of the research study will be sent to the participant as soon as it is available if requested.

Following the receipt of agency staff names, a random selection was made to determine the participants to be included in the study. A

cover letter was sent to those selected and included (Appendix F):

1. A brief description of the study topics.
2. A description of the documents to be completed and approximate length of time needed to complete the documents.
3. A request to return the documents within two weeks.
4. A statement on confidentiality which stated that all materials had been coded and any documents with their name on it would be solely in the hands of the researcher.
5. Participants were assured that the decision to participate or not would not jeopardize their relationship with their agency.
6. Voluntary agreement to participate was obtained by completing and returning the documents.
7. A statement indicating that if they decided to participate, they were free to withdraw at any time.
8. Participants were thanked for their decision to participate and given the telephone number of the researcher if they should have any questions.

A month was allowed for the return of questionnaires with a follow-up letter as a reminder after the time period had gone by. All health department returns were received without the need for follow-up letters. There was approximately a 15% return from second requests to subjects from home health agencies and hospices.

Table 3 provides information about the number of agencies approached for inclusion within the study and the actual number and percent of returns obtained from each type of agency within the study. Of 200 agencies approached, 111 subjects (54.10%) were obtained. Subsequently, 1 individual was dropped from the study for failure to

complete all the instruments. This resulted in a final total of 110 individuals enrolled in the study.

Table 4 presents the number of agencies enrolled, the number of returns and the percentage of returns for each type of agency.

Only two forms had to be returned for completion and these subjects did complete the information fully and return it.

Table 4
Agencies Enrolled, Number of Returns
& Percentage of Returns

	Number	Return	%
Health Departments	80	55	68.75
Home Health Agencies	80	37	46.25
Hospices	40	19	47.50
Total	200	111	54.10

Analysis of Data

Consultation was sought from the Michigan State University Center for Statistical Consulting. The proposal was submitted to a consultant from the Center and a conference followed after review of the document. Suggestions were made regarding the demographic data. It was concluded that length of employment be measured in years only, that the wording of educational experiences be summarized as formal course work and continuing education, and that examples of continuing education be included e.g. workshops, staff development of continuing education. The name of all educational experiences was requested in order to interpret whether the program was ethical in nature. Basically most of the data would be analyzed using correlation coefficients with 0 = non-significant and + = some significance. Reliability of the NABP was determined by split halves, i.e., measuring the internal consistency of

the instrument through dividing the instrument in half, computing a score for each half, and correlating the two sets of scores. A t-test was used on familiarity with the dilemma scores. Gender had been included as a demographic factor but will not be reported in the results since out of 111 respondents only four were males. Analysis of variance (ANOVA) was computed upon the PDS, the NABP and the NDT.

Summary

A total of 110 subjects were enrolled in this study: 54 from public health departments; 37 from home health agencies and 19 from hospices.

Three instruments were used. The first, the PDS collected demographic data, e.g. sex, age, basic education, additional degrees, years of experience in nursing, and any educational experiences that had an ethical component, e.g., a course, part of a course, part of a clinical rotation and continuing education offerings (inservice, staff development or workshops or conferences). The second, the NABP instrument was designed for the study to measure the constructs of patient, autonomy, nurse autonomy, and organizational support with the assumption that there was a relationship between their constructs and levels of ethical reasoning. The third instrument, the NDT which measures responses to 6 ethical dilemmas commonly found in nursing practice. Subjects were asked to respond to three categories in each of the 6 dilemmas. The first was an action choice based specifically on the dilemma. The choices were "Take the action specified", "Can't decide" and "Should not take the action". The second portion presented six issues associated with the dilemma and asked the respondent to rank order in terms of importance (most important from 1 to 6). Then the nurse was asked to indicate on a scale of 1 to 5, if they had been

involved in a similar dilemma by responding to:

1 = Made a decision in similar dilemma.

2 = Knew someone else in a similar dilemma.

3 = Not known anyone in a similar dilemma but dilemma is
conceivable.

4 = Difficult to image the dilemma as it seems remote.

5 = Difficult to take the dilemma seriously as it seems unreal.

Responses to this portion resulted in a F score (familiarity
score).

The ethical judgment scores were correlated (ANOVA) to the
relationship between the demographic data, patient autonomy, nurse
autonomy and organizational support.

Chapter IV

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

The results of the study will be presented by analyzing data collected by each instrument used in the study (the Personal Data Sheet, Nursing Advocacy Beliefs and Practices, and the Nursing Dilemma Test) and the results of the hypothesis testing through the analysis of data with means, standard deviations, Chi-square measures and ANOVA correlations will be presented and explained. A summary of the data will relate the measures to the hypotheses.

One hundred and eleven individuals (55.5%) responded to the request for participation in the study. Subsequently, one individual was removed since her Nursing Dilemma Test was not completed. She felt it was not relevant to her practice. Therefore, no attempt was made to get the information from this individual. Of the remaining respondents, only two had major information missing and the instruments were returned to them with a request to complete the information. They did this and returned the forms to the researcher. The remaining data is based upon a sample of 110 (55%) individuals.

Demographic Data

The following information is based upon the data requested on the Personal Data Sheet (PDS) which consists of demographic characteristics of the persons enrolled in the study, including current place of employment, age, sex, basic educational preparation, additional degrees, number of years employed in nursing, years of experience by type of agency, and types of ethical education received.

Current Place of Employment

Respondents were asked to indicate their current place of employment as public health agency, home health agency or hospice.

Information was collected on the place of employment, i.e., a health department, home health care agency, or hospice and the percent of subjects in each agency is given.

Table 5 presents the information about the place of employment of the subjects within this study by number of individuals, and the percent of individuals in each type of agency; health department, home health care agency and hospice.

Table 5
Place of Employment

	Frequency	%
Health Department	54	49.1
Home Health Agency	37	33.6
Hospice	19	17.3
Totals	110	100%

Age

Subjects were asked to indicate their age in years. Of the 110 respondents, the age range 25-58 years; the mean was 41.26 with an 8.765 standard deviation.

Table 6 presents the age ranges by the type of employing agency. The number of individuals in each age range is presented and the percent of individuals within the range is given by for each type of agency.

The minimum age of 25 years for employment in community health agencies would be an expected finding since only 2 out of 110 individuals found employment in community health agencies without preceding hospital experience. Nurses employed in hospices were younger than the nurses in other types of agencies with a range of 25-47 years.

Table 6
Age Range by Agency

	Health Dept N=54		Home Health Care N=37		Hospice N=19	
Range	#	%	#	%	#	%
25-34	10	18.5	11	29.8	8	42.1
35-40	9	16.7	9	24.3	5	26.3
41-50	21	38.9	12	32.4	6	31.6
52-58	14	25.9	5	13.5	-	-
Totals	54	100%	37	100%	19	100%

The Chi-Square was 10.11 with 6 degrees of freedom and .12011 significance which did not meet significance at the .05 level. The hypothesis H_{01} , (there is no significant relationship between ethical judgment scores and age), is accepted.

Gender

Subjects were asked to supply information regarding their gender. There were 106 females (96.4%) and 4 males (3.6%) for a total of 110 individuals. Three males were employed by health departments and 1 male was employed by a home health care agency. There was a ratio of .96 females to males.

The Chi-square had a value of 1.376 with 2 degrees of freedom and a significance of .50242 which did not meet significance at the .05 level. Due to the small number of males, the subsequent data omits any designation related to gender as a variable.

Educational Preparation

The type of basic nursing preparation was requested included the categories of Diploma, Associate Degree in Nursing and Bachelor of Science in Nursing.

Of the 54 subjects employed in health departments, 21 individuals were prepared at the baccalaureate level, 20 at the associate degree

level, and 13 were educated in diploma programs.

There were 37 individuals employed in home health agencies with 16 individuals prepared at the baccalaureate level, 10 had associate degrees in nursing and 11 individuals were diploma graduates.

Of the 19 respondents employed in hospices, 7 had baccalaureate preparation, 8 were associate degree graduates and 4 were prepared in a diploma program.

Table 7 presents the number and percent of graduates in each category by the type of agency.

Table 7
Basic Educational Preparation
by Type of Agency

	Health Dept N=54		Home Health Agency N=37		Hospice N=19	
	#	%	#	%	#	%
Diploma	13	24.07	11	29.73	4	21.05
ADN	20	37.04	10	27.03	8	42.11
BSN	21	38.89	16	43.24	7	36.84
Totals	54	100%	37	100%	19	100%

Additional Degrees

Subjects were asked to provide information on any other degrees (nursing or non-nursing) that they had obtained since their basic nursing education. Seventeen individuals (15.5%) indicated that they possessed at least one other degree ranging from associate arts degrees to master's degrees for a total of 19 degrees beyond basic educational preparation.

The eight additional degrees listed by seven employees of health departments were:

1. BA (Sociology/Economics)
2. BA in Administration and Gerontology (basic education, diploma)
3. BS in Health Sciences; (not specified) and Master of Arts (not specified) (1 individual)
4. BS in Health Studies
5. MA in Administration and Supervision
6. MS in Parent and Child, and
7. MA (not specified).

Table 8 presents the additional degrees obtained beyond the basic educational level. The information presented includes the number of individuals receiving degrees beyond their basic educational level, the name of the degree and the percent of degrees obtained by type of employing agency.

In home health care agencies, 5 individuals indicated additional degrees:

1. BS degree which was dual with a BSN
2. A BSN, (formerly Diploma graduate) and a Master's of Science in Biology
3. A BA in History;
4. A BA in education, and
5. A Master's in Administration.

In hospices, 4 individuals reported 5 additional degrees:

1. MSN;
2. BS in Health Studies;
3. BA in Education, and MA in Special Education (1 individual); and
4. ADN (formerly an LPN).

Table 8
Additional Degrees Beyond Basic Education

	Health Dept. N = 54		Home Health Agency N=37		Hospice N = 19	
	#	%	#	%	#	%
AA	-		-		1	5.2
ADN	-		-		1	5.2
BA	2	3.7	2	5.4	1	5.2
BS	2	3.7	-		1	5.2
BSN	-		1	2.7	-	
BS/BSN	-		1	2.7	-	
MA	2	3.7	-		1	5.2
MS	-		1	2.7	-	
MSN	2	3.7	1	2.7	-	
Total	8	14.8	6	16.2	5	26.3

Of the 19 degrees obtained, only 5 were in nursing programs. This means that upon graduation from the basic nursing program only 4.5% of respondents had nursing content in their additional formal education.

Although not requested, individuals reported educational efforts in progress. In Health Departments 4 individuals were enrolled in BSN programs and 1 in a MPA program. In Home Health Agencies, 1 individual was enrolled in an MSN program.

The Chi-square value for basic nursing education was 11.173 with 6 degrees of freedom and a significance of .08316 which did not meet significance at the .05 level. The null hypothesis H_{02} , (there is no significant relationship between ethical judgment scores and educational preparation) was accepted.

Number of Years Employed in Nursing

Respondents were asked to supply information regarding the length of their experience in nursing. The range of years worked was from 3 to 336 years across the 3 types of agencies. The mean was 16.5 with the median 16 and the standard deviation 9.630 for the number of years

employed in nursing.

The Table 9 presents the means, ranges, and standard deviations for the number of years employed in nursing by type of agency.

Nurses employed in hospices have slightly less experience in nursing with about a 9 year difference in the range.

Overall types of agencies, the span of the nurses work experience was 3-36 years. The mean was 16.5 with a median 16 and a standard deviation of 9.630.

Table 9
Years Employed in Nursing by Type of Agency

	Health Dept N=54	Home Health Agency N=37	Hospice N=19
Range	3-36 years	3-36 years	3-27 years
Mean	18.7	16.1	12.1
STD	9.3	9.4	7.9

The Chi-square has a value of 6.738 with 6 degrees of freedom and a significance of .34575 which did not meet significance at the .05 level.

The null hypothesis H_{05} , (there is no significant relationship between ethical judgment scores and number of years employed in nursing) was accepted.

Work Experience by Employing Agency

The next category to be examined was the experience background of the graduates in terms of where they had been employed throughout their career and the number of years employed in each category of possible work experiences, i.e., hospitals, health departments, health home health care, and hospices (see Appendix H).

The categories presented to the respondents were 5 or more years, 2-4 years, less than 2 years and no experience in the particular type of

agency.

Table 10 presents the frequency and percentages of hospital work experience. Sixty-two persons reported more than 5 years. Thirty-five individuals reported between 2 to 4 years, while 10 individuals had less than 2 years and 2 individuals had no experience in a hospital.

Virtually all subjects begin their work experience in a hospital setting. Only 2 (1.8%) of the nurses in this study did not have any hospital experience prior to employment in a community health agency. Upon graduation many students are encouraged to seek employment in a hospital which is viewed as a structured experience which can assist a new graduate nurse to refine skills with supervision.

Table 10
Hospital Work Experience in Nursing

	Freq.	%	Cum %
5 or more years	62	56.9	56.9
2-4 years	35	32.1	89.0
< 2 years	10	9.2	98.2
none	2	1.8	100.0

Students often feel that this is an acceptable recommendation. Also, hospitals generally have vacancies, and therefore, employment in a hospital is practically ensured for graduating seniors.

The Chi-square was 7.425 with 6 degrees of freedom and a significance of .28325 which did not meet significance at the .05 level.

Table 11 presents the number of years employed in public health departments. Fifty-two individuals (47%) have never been employed in a public health department while 19 individuals (17%) have worked less than 2 years which means that of the total population of 110 individuals, only 39 (36%) have had over two years or more of experience in public health nursing.

Table 11
Public Health Department Work Experience

	Freq	%	Cum %
5 or more yrs.	29	26.4	26.4
2-4 years	10	9.1	35.5
< 2 years	19	17.3	52.7
none	52	47.3	100.0

The Chi-square was 96.229 with 6 degrees of freedom and a significance of .00000 which did not meet significance at the .05 level.

Table 12 presents experience information on individuals employed in home health agencies. Twenty-seven (25%) individuals have never been employed in a home health agency, forty-eight individuals (43.6%)

Table 12
Home Health Agency Work Experience

	Freq	%	Cum %
5 or more yrs.	22	18.18	18.18
2-4 years	10	16.36	34.54
< 2 years	21	19.09	53.63
none	27	24.54	100.00

(43.6%) have less than 2 years of experience, twenty-two (18%) of the nurses employed in home health agencies have 5 or more years.

The Chi-square was 55.122 with 6 degrees of freedom and a significance of .00000 which did not meet significance at the .05 level for home health agency experience.

Table 13 represents the number of years employed in a hospice. Eighty-six (78.18%) of the nurses in this study have never been employed in a hospice agency. Only 10.91% have had two or more years of hospice nursing experience.

Four individuals (3.64) have only five or more years of hospice work experience.

Table 13
Hospice Work Experience

	Freq	%	Cum %
5 or more yrs.	4	3.64	3.64
2-4 years	8	7.27	10.91
1-2 years	12	10.91	21.82
none	86	78.18	100.00

The Chi-square was 55.122 with 6 degrees of freedom and a significance of .28325 which did not meet significance at the .05 level for hospice work experience.

Although Medicare reimbursement has been available for services in the home since 1965 as late as 1982, the federal government and third party payers were still exploring Medicare payment for hospice services.

Over all types of agencies, the null hypothesis H_{04} , (there is no significant relationship between ethical judgment scores and place of employment) (public health department, home health care or hospice) is accepted.

The null hypothesis H_{05} , (there is no significant difference between ethical judgment scores and the length of time employed in a community nursing agency) was rejected for home health agencies. There was a .3885 correlation at the .05 level of significance between experience and practical considerations.

For health departments and hospices, the null hypothesis, H_{05} was accepted, there is no significant relationship between ethical judgment scores and length of time employed in a community nursing agency.

Educational Experiences Related to Ethics in Nursing

Subjects were asked to provide information on any educational experiences with an ethical component which they had in their basic education both academic and clinical. The categories were: a course,

part of a course, or a clinical rotation. In addition, information was requested regarding any continuing education e.g., workshops, staff development or inservices.

Of the 110 subjects, asked whether they had a course with ethical content in their basic education, 69 (59.1%) responded "no." In the second category, ethical content in a portion of a course, 85 (77.3%) responded "no." Ninety individuals (81.8%) indicated that they did not have ethical teaching in a clinical rotation and 74 (67.3%) individuals indicated that they did not have any ethical content in any continuing education experiences.

Table 14 presents the number, means and standard deviations of all types of ethical education (a course, part of a course, clinical rotation and continuing education) for the total sample.

Table 14
Individuals with Ethical Education
by Type of Experiences

	Course	Part of a Course	Clinical Rotation	Continuing Education
Number	45	24	19	35
Mean	1.409	1.220	1.174	1.231
STD	.494	.416	.381	.469

In Table 15, types of ethical education obtained is presented for health departments. The information is categorized by basic educational preparation. Thirty-six employees (66%) reported 72 educational experiences across the four types of education specified by their basic educational preparation. This means that 18 individuals (34%) have not participated in any ethical education experience in either their basic educational program or in continuing education activities.

Table 15
Ethical Education Experiences of Nurses Employed
in Health Departments by Educational Level

Sample = 54	BSN N=18	ADN N=20	Diploma N=16
Experiences = 72	# %	# %	# %
Course	8 11.11	11 15.25	6 8.33
Part of a course	8 11.11	6 8.33	2 2.77
Clinical rotation	3 4.17	8 11.11	3 4.17
Continuing educ.	6 8.33	6 8.33	5 6.94
Total	25 34.72	31 43.02	16 22.22

For courses, respondents were asked to provide the name of the educational experience. Baccalaureate degree nurses provided the following titles below. The numbers after a category represent the number of nurses reporting the title:

1. Ethics in Health Care,
2. Ethics,
3. Medical Ethics (2),
4. Ethics and Human Genetics,
5. Professional Ethics, and
6. Ethical Aspects of Nursing.

Associate degree nurses listed the following titles:

1. Biomedical ethics (2),
2. Nursing ethics (3),
3. Ethics in Nursing (2),
4. Bioethics (3),
5. Ethical Dilemmas; Health Care in the U.S., and
6. unknown title (3).

For nurses graduating from a diploma program, the following courses were taken:

1. Medical Ethics (2),
2. Ethics in Nursing,
3. Nursing Ethics (2), and
4. title unknown (2).

When referring to ethical content which was provided in a portion of a course, baccalaureate prepared nurses provided the following titles:

1. Metaphysics and Religion,
2. Professional Adjustment,
3. The Professional Nurse,
4. Sociology, and
5. title unknown (3).

For associate degree nurses the following titles were listed:

1. Nurse Management (2),
2. Health Care Management, and
3. Introduction to Professional Nursing/Community Nursing.

One nurse prepared in a diploma program listed the title of "The Nurse and the Individual".

For the ethical content provided in a clinical rotation, a medical/surgical rotation was listed by 1 baccalaureate prepared nurse.

Associate degree nurses listed the following clinical areas as having provided ethical content:

1. Neo-natal,
2. Oncology (3),
3. Psychology,
4. Medical Surgical (4), and
5. Integrated into all rotations.

Two diploma nurses listed the following ethical content as:

1. Medical/surgical rotation, and
2. Integrated into all clinical rotations.

In reporting continuing education experiences, baccalaureate nurses reported 8 experiences with the following titles:

1. Theology,
2. Ethical Decision Making in the 90's,
3. Ethical Dilemmas in a Hospital,
4. Working with a Team Approach in a Hospital,
5. Nursing Ethics:
6. Inservice from the Medical Ethics Committee, and
7. title unknown (2).

For associate degrees nurses the following titles were provided:

1. Michigan Nurses Convention,
2. American Nurses Convention,
3. Health Department inservices,
4. Health Education Seminar;
5. Staff Development in a hospital and health department,
6. Health Care Administration,
7. Basic Business Law,
8. Ethical Dilemmas in the Workplace, and
9. title unknown (2).

Diploma nurses provided the following titles:

1. U of M Workshop,
2. Ethical Dilemmas (2),
3. Inservice from an attorney,
4. Workshop (title unknown), and
5. Medical Ethics.

Thirteen nurses (35%) employed in home health agencies reported a

total of 29 educational experiences in the four types of possible educational experiences. The information is presented in Table 17.

Nurses with baccalaureate degrees listed the following courses,

1. Ethics in Nursing
2. Bioethics
3. Medical Ethics
4. Ethics.

One nurse with an associate degree listed the following course with the title, "Death and Dying."

Table 16
Educational Experiences of Nurses Employed
in Home Health Agencies by Educational Level

Sample = 37	BSN N=16		ADN N=10		Diploma N=11	
Experiences = 72	#	%	#	%	#	%
Course	3	4.17	1	1.39	6	8.33
Part of a course	5	6.94	-	-	-	-
Clinical Rotation	2	2.77	1	1.39	1	1.39
Continuing Educ.	5	6.94	1	1.39	4	5.55
Totals	15	20.82	3	4.17	11	15.27

Five diploma nurses with listed the following courses,

1. Ethics in Nursing
2. Death and Dying
3. Medical Ethics
4. Practical Ethics. and
6. Ethics.

Five nurses prepared at the baccalaureate level reported the following titles as courses in which a portion of the course contained content related to ethics.

1. Existentialism (2),

2. Philosophy,
3. Nursing 341, and
4. Leadership in Nursing.

In reporting ethical content in a clinical rotation,

1. Clinical content integrated into all clinical (2 BSN nurses),
2. Unspecified area (1 ADN),
3. Medical-surgical (1 Diploma), and
4. Oncology (1 Diploma).

Fourteen nurses (74%) who were currently employed in hospices reported 19 different ethical educational experiences. Table 17 provides the information on the educational experiences.

Table 17
Education Experiences of Nurses Employed
in Hospices by Educational Level

Population = 19	BSN N=6		ADN N=7		Diploma N=6	
Experiences = 72	#	%	#	%	N	%
Course	2	2.77	3	4.17	2	2.77
Part of a Course	2	2.77	1	1.39	2	2.77
Clinical Rotation	-		1	1.39	-	
Continuing Educ.	2	2.77	2	2.77	2	2.77
Totals	6	8.31	7	9.72	6	8.21

Baccalaureate nurses reported the following courses:

1. Ethics in the Professions,
2. University class (unspecified).
3. Philosophy

Courses taken by nurses with an ADN were:

1. Biomedical Ethics,
2. Moral Philosophy,

3. Leadership and Management.

Courses taken by Diploma nurses:

1. Medical ethics (2 Diploma).

Part of a course by Baccalaureate nurses:

1. Nursing 430 (dilemma paper), and
2. A humanity requirement.

Part of a course by associate degree nurses:

1. Basic philosophy,
2. Legal & Ethical Decision-making in Nursing

Part of a course taken by diploma nurses:

1. Nursing Perspectives, and
2. Hospital Issues and Ethics.

Only 1 individual, an associate degree graduate, reported an ethical component in a obstetrical clinical rotation.

In ethical continuing education experiences by baccalaureate prepared nurses:

1. National Hospice Association Conference.

For associate degree nurses continuing education experiences were:

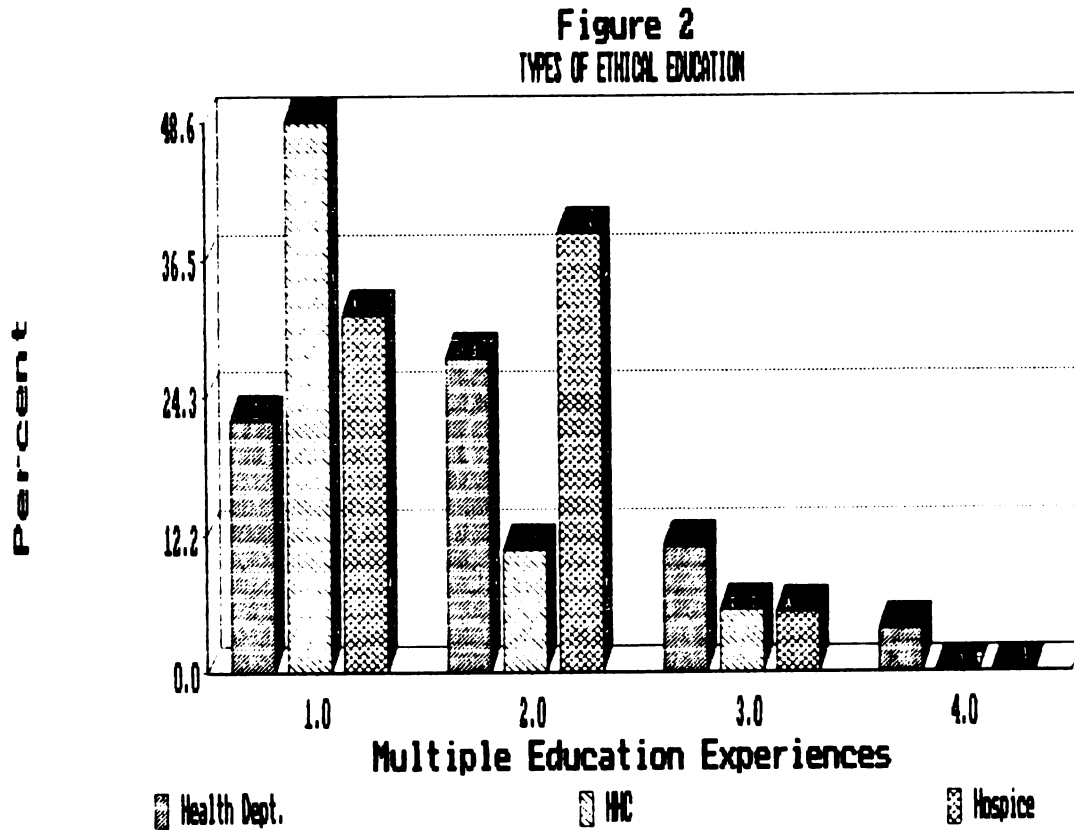
1. Bioethics: A Blueprint for Oncology Professionals,
2. Euthanasia: Active and Passive, and
3. Care of the Hopelessly Ill.

For Diploma nurses continuing education experiences were:

1. Bereavement Workshop, and
2. Ethical Issues in Hospice Care in the 1990's.

In summary, across all categories of ethical instruction, individuals range from no ethical content up to four types of ethical educational experiences (course, part of a course, clinical rotation and continuing education. Figure 2 graphically presents the frequency of

subjects having from one to a multiple of four different types of ethical education by type of agency.



In reporting whether the individual had a course in ethics, Table 18 presents the information by type of employing agency.

Table 18
Had A Course in Ethics

	Health Dept. N=54	Home Health Agency N=37	Hospice N=19
Frequency	29	26	10
Percent	53.7	70.2	52.6

In reviewing the information over all types of agencies, the Chi-square value was 2.889 with 2 degrees of freedom and a significance of .23585 which did not meet significance at the .05 level.

The same information was provided if the ethical content in a

course comprised only a portion of the course. Table 19 presents the number of persons reporting a course in ethics and the percent by type of agency.

Table 19
Had Ethical Content in a Portion of a Course

	Health Dept. N=54	Home Health Agency N=37	Hospice N=19
Frequency	11	6	7
Percent	20.3	16.2	36.8

For ethical content in a portion of a course, the Chi-square value was 3.206 with 2 degrees of freedom and a significance of .20126 which did not meet significance at the .05 level.

Subjects also supplied information on ethical content provided during a clinical rotation. The respondents were asked to indicate the clinical rotation in which they had the ethical content and that was reported on pages 99, 101 and 103 under clinical rotation. Table 20 presents the information on ethical education obtained in a clinical rotation.

Table 20
Had Ethical Content in a Clinical Rotation

	Health Dept. N=54	Home Health Agency N=37	Hospice N=19
Frequency	11	6	7
Percent	20.4	16.2	36.8

In a clinical rotation with an ethical component, the Chi-square value was 6.053 with 2 degrees of freedom and a significance of .44848 which did not meet significance at the .05 level.

The null hypothesis (H_{06}) is accepted. There is no significant relationship between ethical judgment scores and instruction in ethical

principles and practices (i.e., a course in ethics, part of a course, or part of a clinical experience).

Information on continuing education was also requested by asking for any ethical educational experiences through staff development, workshops or other continuing education activities. Table 21 provides information on continuing education activities by type of agency.

Table 21
Had Ethical Education - Continuing Education

	Health Dept. N=54	Home Health Agency N=37	Hospice N=19
Frequency	18	11	6
Percent	33.3	29.7	31.6

For ethical education as continuing education, staff development or workshops, the Chi-square value was .18203 with 2 degrees of freedom and a significance of .91300 which did not meet significance at the .05 level.

The null hypothesis (H_{07}) is accepted. There is no significant relationship between ethical judgment scores and the amount of continuing education (workshops, staff development or conferences).

In summary, all of the null hypotheses from H_{01} to H_{07} were accepted with the exception of H_{05} . There was a significant relationship between experience and practical considerations for home health agencies which met the .05 level of significance.

The standard deviations and other information provided on the respondents suggest that although these nurses are employed in different types of community agencies, they are not dissimilar. In fact, they could be considered one population group rather than subpopulations. Age, length of experience, basic educational preparation, additional

education following graduation and education with an ethical focus (both academically and post-graduation) seems to be fairly evenly distributed throughout the groups.

Although education alone is not sufficient to ensure ethical behavior, it can provide the foundation for clarifying whether a patient situation is a moral dilemma or not. Other conditions which have been suggested as necessary are judging one course of action as the moral thing to do, deciding to take action and the persistence, follow through and strategies to carry out the goal of behaving morally.

Nursing Advocacy Beliefs and Practices

The Nursing Advocacy/Beliefs and Practices instrument was designed to measure advocacy through the following constructs: patient autonomy, nursing autonomy, and organizational support. The assumption was made that an orientation to ethical principles would be evident based upon examining nurse's beliefs about the rights of patients, their ethical responsibilities as a professional and their relationship to the organization and the degree of support it provides for the nurse.

There are eight items in the instrument which would reflect the construct of an ethical orientation to patient autonomy:

1. the right to self-determination (2 items)
2. the right to obtain the truth (2 items)
3. beneficence (doing good) (2 items)
4. access to care (2 items).

There are 12 constructs in the instrument related to nurse autonomy. The items reflecting nurse autonomy are:

1. professional decision-making
2. accountability of the nurse (3 items)
3. non-maleficence (do no harm)

4. truth-telling
5. professional care planning
6. protecting the patient's right to self-determination
7. paternalism
8. nurse autonomy
9. confidentiality

The third construct in the instrument relates to organizational support of the nurse in practice. The 8 questions related to this construct are:

1. agency philosophy,
2. educational opportunities for staff members (2 items),
3. the autonomy of the nurse to plan her schedule according to patient needs,
4. freedom to plan without the need for supervisor approval (2 items),
5. supervisor stimulation of ethical practice, and
6. supervisor assistance in dealing with ethical dilemmas in the nurse's practice.

Items on the NABP were on a Lickert Scale of strongly agree which equaled 1 and strongly disagree which equaled 5.

In the construct of patient autonomy all responses were agree with a possible range of 1 = strongly agree and 2 = agree which results in a score range of 8 through 16.

The nurse autonomy category contained 12 items with 1 = strongly agree and 2 = agree; 11 items were agree (11-22) and 1 item disagree which would result in an score range of 15 through 27 (11+4 and 22+5).

The organizational support category contains 8 items with 7 agree and 1 disagree with a score range of 11-19.

Scores above these ranges indicate that individuals had used the categories of "undecided", "disagree" and "strongly disagree" in their responses. Scores below the range would indicate, an agreement with items which were ranked disagree.

Over all types of agencies, the range of scores for each category are given with the ranges, means and standard deviations for patient autonomy, nurse autonomy and organizational support. The values for patient autonomy range from 8-21 with a mean of 12.309 and a standard deviation of 3.052. The range of scores for nurse autonomy was 14-34 with a mean of 22.336 and a standard deviation of 4.548. Organizational support has a range of 10-36 with a mean of 19.845 and a standard deviation of 5.231.

In the following tables, the range, mean and standard deviations for patient autonomy, nurse autonomy and organizational support are given by type of agency.

The Table 22 presents the ranges, means and standard deviations for health departments.

Table 22
NABP Score Ranges, Means and Standard Deviations
for Health Departments

	Patient Autonomy	Nurse Autonomy	Organizational Support
Range	9-20	14-32	21-54
Mean	13.870	22.092	22.0370
STD	3.052	4.663	4.013

Table 23 presents the scores for home health care agencies for the constructs of patient autonomy, nurse autonomy, and organizational support by providing the score ranges, means and standard deviations.

Table 23
NABP Score Ranges, Means and Standard Deviations
For Home Health Care Agencies

	Patient Autonomy	Nurse Autonomy	Organizational Support
Range	8-15	15-34	13-37
Mean	10.648	22.43	17.676
STD	2.137	4.400	4.595

Table 24 presents information on ranges, means and standard deviations) for the constructs of patient autonomy, nurse autonomy and organizational support for hospices.

The scores for the categories patient autonomy, nurse autonomy and organizational support are presented individually for the three types of agencies by percentage of the "agree" and the "disagree" designations.

Table 24
NABP Score Ranges, Means and Standard Deviations
For Hospices

	Patient Autonomy	Nurse Autonomy	Organizational Support
Range	8-16	15-32	14-28
Mean	11.105	22.484	17.842
STD	2.903	4.693	4.031

ANOVA was used to determine significance.

Table 25 presents the correlations for patient autonomy, nurse autonomy, and organizational support for all agencies.

Table 25
All Agencies
Patient Autonomy, Nurse Autonomy & Organizational Support
Correlation Coefficients

	PA	NA	OS
Patient Autonomy	1.000	.5040**	.1639
Nurse Autonomy	.5040**	1.000	.0697
Organ. Support	.1639	.0697	1.000
* - Significance level .05 ** - Significance level .01			

The only significant correlation was between nurse autonomy and patient autonomy at the .01 level of significance.

The following figures graphically present the patient autonomy, nurse autonomy and organizational support scores (Figures 3, 4, 5).

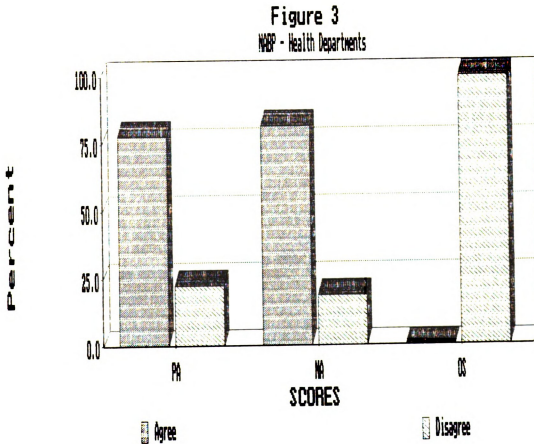


Figure 4
NABP - HOME HEALTH CARE

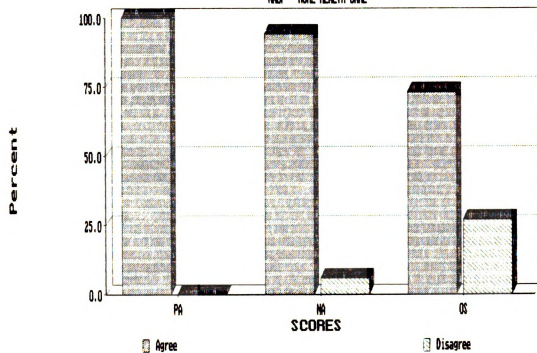


Figure 5
NABP - HOSPICES

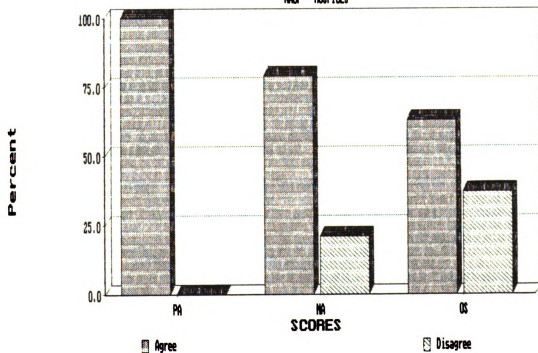


Table 26 presents correlations between patient autonomy, nursing autonomy and organizational support for health departments.

Table 26
Health Departments
Patient Autonomy, Nurse Autonomy & Organizational Support
Correlation Coefficients

	PA	NA	OS
Patient Autonomy	1.000	.6750**	-.1290
Nurse Autonomy	.6750**	1.000	.0929
Organ. Support	-.1290	.0929	1.000
* - Significance level .05 ** - Significance level .01			

The only significant correlation between nursing autonomy and patient autonomy was at the .01 level of significance.

Table 27 presents the information on the three constructs (patient autonomy, nurse autonomy and organizational support).

Table 27
Home Health Care Agencies
Patient Autonomy, Nurse Autonomy & Organizational Support
Correlation Coefficients

	PA	NA	OS
Patient Autonomy	1.000	.5099**	-.0317
Nurse Autonomy	.5099**	1.000	.1940
Organ. Support	-.0317	.1940	1.000
* - Significance level .05 ** - Significance level .01			

For home health care agencies, the only significant correlation was between nursing autonomy and patient autonomy at the .01 level of significance.

Table 28 presents the correlations between patient autonomy nursing autonomy and organizational support for hospices.

Table 28
Hospices
Patient Autonomy, Nurse Autonomy & Organizational Support
Correlation Coefficients

	PA	NA	OS
Patient Autonomy	1.000	.6045**	.1629
Nurse Autonomy	.6045**	1.000	-.0698
Organ. Support	.1629	-.0689	1.000
* - Significance level .05 ** - Significance level .01			

The only significant finding for hospices was that nursing autonomy and patient autonomy were correlated at the .01 level of significance.

Therefore, the null hypothesis H_{08} (there is no significant relationship between nurses beliefs' about patient autonomy and ethical reasoning) would be rejected with a significance level of .01 across all types of agencies. The null hypothesis H_{09} (there is no significant relationship between nurses beliefs' about nurse autonomy and ethical reasoning) would also be rejected with a significance level of .01 across all agencies.

The null hypothesis H_{010} would be accepted since there are no significant relationships between organizational support and ethical judgment.

The correlation of patient autonomy and nurse autonomy relates to the assumption that nurses who reason autonomously based upon known ethical standards would respect the autonomy of patients.

Nursing Dilemma Test (NDT)

On the NDT, subjects are asked to respond to three sections: A, B, and C (see appendix II).

Section A relates to making action choices in each dilemma. In this section, the question is asked, "What should the nurse do?". Three

options are provided and subjects are asked to select one response, The options are specific to each of the six dilemmas.

1. take the specified action,
2. can't decide
3. would not take the specified action.

In each dilemma, a score of 1 is given to take the action, a score of 2 to is given if the subject cannot decide on action, and a score of 3 is given if the subject would not take the described action.

Section B has the subject rank 6 items of importance in each dilemma.

Subjects are measured on six questions for each dilemma which represent the following scores:

1. nursing principled (2 scores per dilemma),
2. a practical consideration score,
3. developmental stages (3 scores per dilemma), and
4. familiarity with the dilemma (5 scores).

The nursing principled score is interpreted as the relative importance given to principled moral considerations. The highest NP score is 66.

The relative importance given to practical considerations is indexed by adding the scores of items that represented the practical considerations across all six dilemmas. The highest possible score is 36 with 1 practical consideration per dilemma. The following null hypothesis relates to practical considerations.

H_{011} = There is no relationship between nursing principled reasoning and practical considerations.

Section C measures familiarity with the dilemma.

The following hypothesis relates to familiarity with the dilemma.

H_{012} = There is no relationship between nursing principled reasoning and familiarity with the dilemma.

Action Choices

The action choice in each of the six dilemmas totaled for all 3 types of agencies had a total value of 660 (i.e., 110 individuals x 6 dilemmas = 660). Table 29 reports the frequency and percents of the choices as to whether the nurse would take action, was undecided about taking action or would not take the action.

Table 29
Action Choices - All Agencies

Take Action	Undecided	No Action
298 45.2%	154 23.3%	228 34.5%

The above information was compiled but not tested against the hypothesis.

It is included since it represents the type of decisions that nurses make in situations which have an ethical component. The subjects did proceed with ranking the items in each dilemma as requested regardless of their action choice above.

Figures 6, 7, and 8 graphically present action choices of the respondents by presenting the results (in percentages) of the decisions made across the 6 nursing dilemmas. Figure 6 represents the "take action" choice. Figure 7 represents "undecided", and Figure 8 represents "would not take action".

Figure 6
TAKE THE ACTION

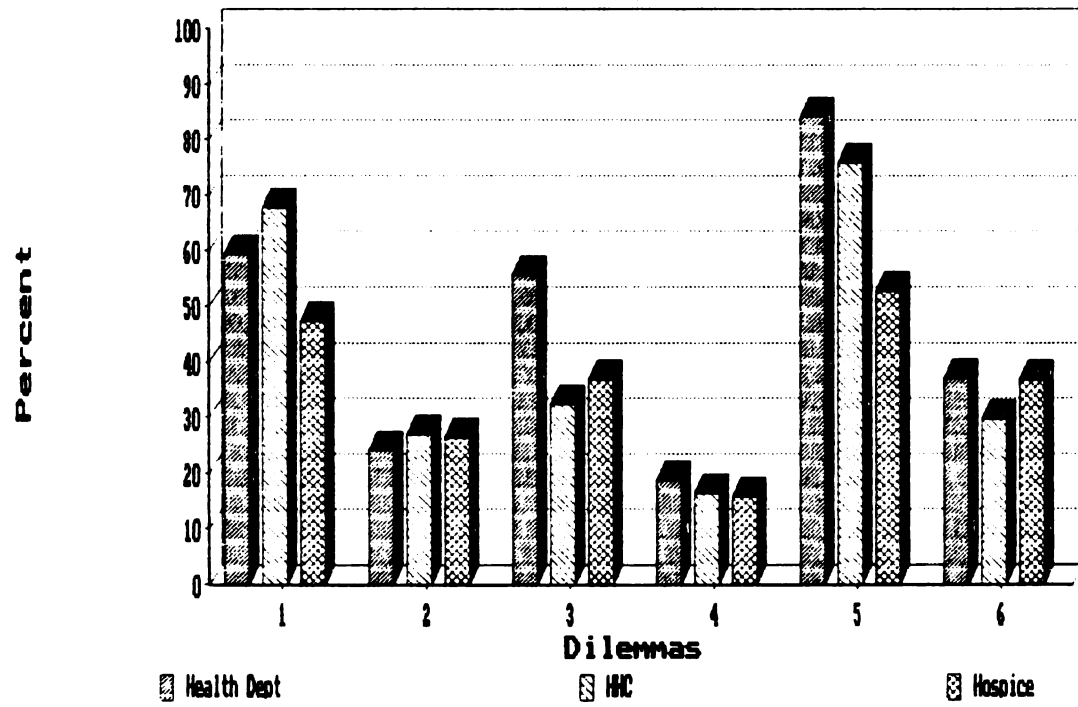


Figure 7
CAN'T DECIDE ON ACTION

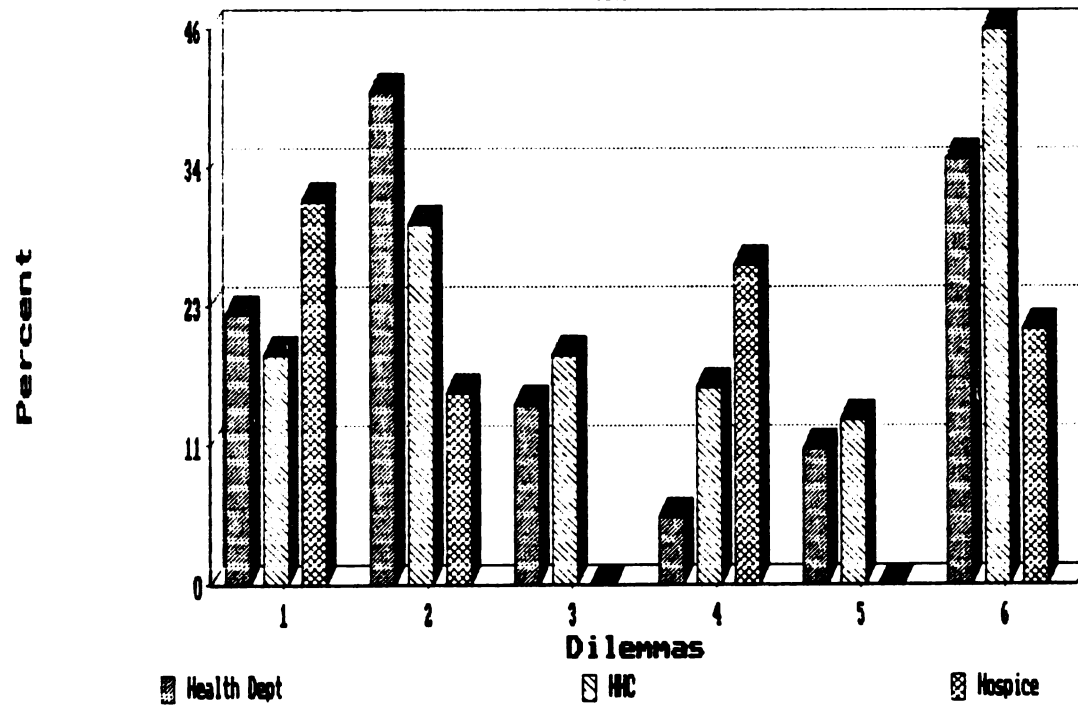
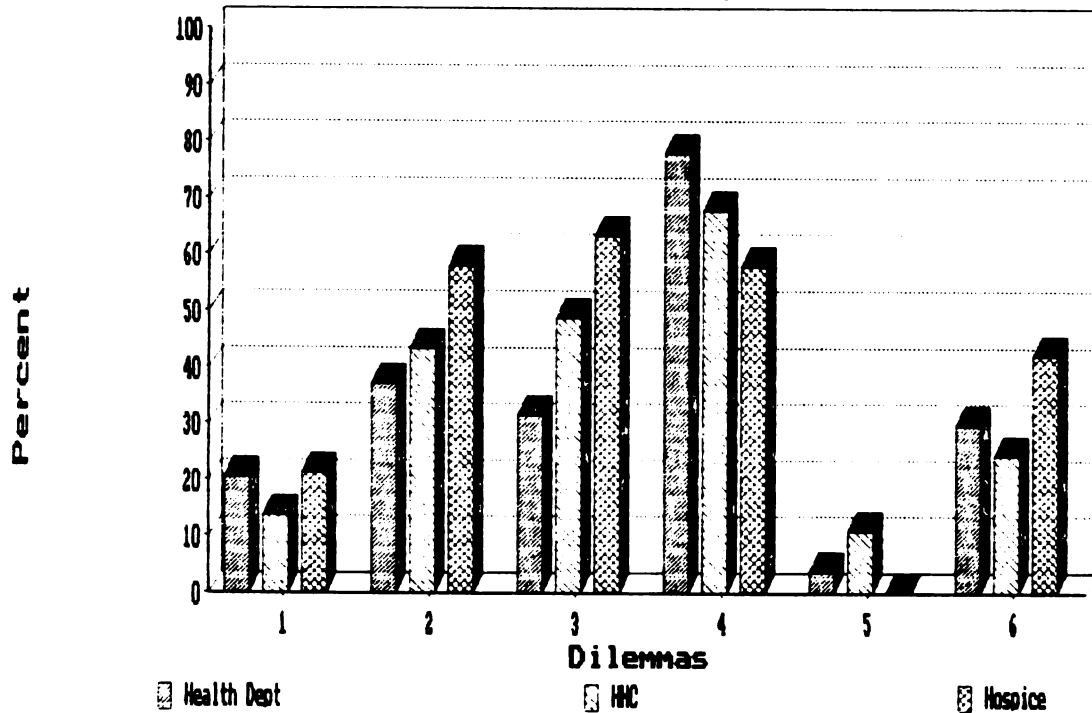


Figure 8
WOULD NOT TAKE THE ACTION



Nursing Principled Reasoning

Table 30 presents the items as ranked in Section B, the score ranges, means and standard deviations are given by type of agency.

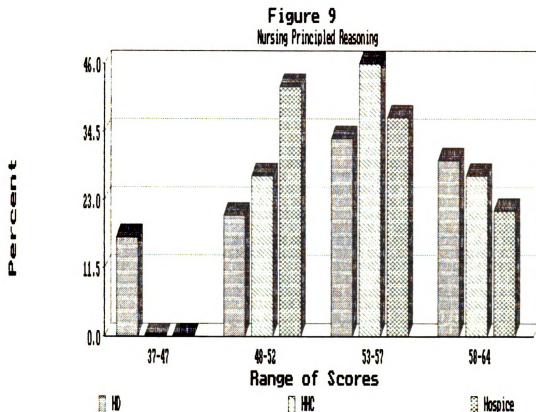
Table 30
Nursing Principled Scores
All Agencies

	Health Dept.	Home Health	Hospice
Range	37-65	42-63	49-64
Mean	53.611	54.351	54.736
STD	6.067	4.522	4.519

Figure 9 graphically represents the range of scores (37-47; 48-52; 53-57; and 58-64) in percentages for nursing principled reasoning for each type of agency.

The greatest magnitude of scores fall between the ranges of 48-

57, which includes 68 subjects or 62.7% of the population.



Practical Considerations

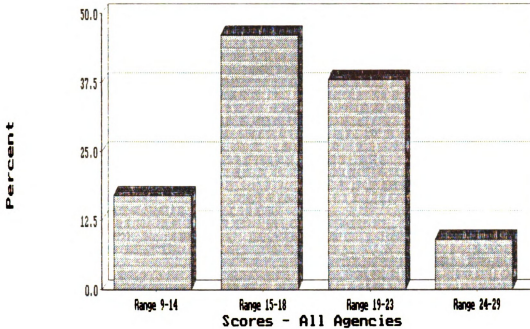
Practical considerations scores are presented for all types of agencies in Figure 10.

The following correlations for nursing principled reasoning and practical considerations are presented in Table 31.

Table 31
Nursing Principled Reasoning
& Practical Considerations

	All agencies	Health Department	Home Health	Hospice
	NP	NP	NP	NP
Practical Considerations	-.4355**	-.4033**	-.4921**	-.3524
** Significance level .01 * Significance level .05				

Figure 10
Practical Considerations



The relationship between practical considerations and nursing principled reasoning was a negative correlation.

There were no significant relationships between nursing principled reasoning and practical considerations for hospices.

The null hypothesis H_{011} = There is no relationship between nursing principled reasoning and practical considerations is rejected for the over all scores, health departments and home health agencies, but accepted for hospices.

Familiarity Scores

The familiarity score measures the degree to which the subjects have encountered a situation in nursing practice which is similar to the nursing dilemma described. The subject responds to 5 items on a Lickert scale:

1. Made a decision in a similar dilemma.

2. Knew someone in a similar dilemma.
3. Do not know anyone in a similar dilemma, but the dilemma is conceivable.
4. Difficult to imagine the dilemma as it seems unreal.
5. Difficult to take the dilemma seriously as it seem unreal.

A familiarity score of 6-17 indicates that the respondent was familiar with the dilemma and a score of 18-30 indicated unfamiliarity with the dilemma.

Table 32 contains the percent of scores classified as familiar or unfamiliar by the type of agency. Ranges, means and standard deviations are also provided.

Table 32
Familiarity with Dilemmas in All Agencies

	Health Dept N=54	Home Health Agency N=37	Hospice N=19
	%	%	%
Familiar (6-17)	46.30	91.89	89.49
Unfamiliar (18-30)	53.70	8.11	10.52
Range	10-25	6-18	6-20
Mean	17.81	11.60	14.05
STD	3.46	3.45	3.32

Figure 11 graphically presents percentage data on familiarity scores by type of agency.

Figure 11
FAMILIARITY SCORES

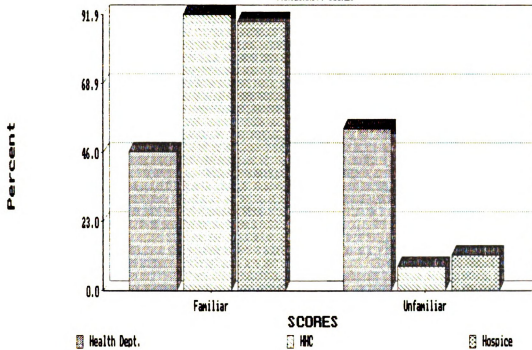


Table 33 presents the correlation coefficients for familiarity over all types of agencies.

Table 33
All Types of Agencies
Familiarity Score
Correlation Coefficients

	PA	OS	F
Patient Autonomy	1.000	-	.3123**
Organ. Support	-	1.000	.2846**
Familiarity	.3123**	.2846**	1.000
* - Significance level .05 ** - Significance level .01			

Other correlations for familiarity were:

Table 34
Nursing Principled Reasoning
& Familiarity

	Health Dept	Home Health	Hospice
	NP	NP	NP
Familiarity Nurs. Principled	.2717* 1.000	-.2312 1.000	.4067 1.000
** - Significance level .01 * Significance .05			

There were no significant correlations on nursing principled reasoning and familiarity for home care agencies and hospices.

The null hypothesis H_{012} , there is no relationship between nursing principled reasoning and familiarity, is rejected for health departments at the .05 level of significance and the null hypothesis H_{012} is accepted for home health care agencies and hospices.

Summary

Three instruments were used to study various attributes which were considered to be important and possibly related to nursing advocacy as an ethical practice model.

The first instrument was the PDS which explored various demographic data: age, basic educational preparation, place of employment, years of experience by the type of agency, and four types of ethical education experiences.

Experience was correlated with practical considerations for home health agencies only. The correlation was .3886 at the .05 level of significance.

All other hypotheses from the PDS were accepted since there was not significant relationships between the demographic data and other

studied variables.

The NABP, the second instrument measured three constructs: the nurse autonomy, patient autonomy and organizational support.

Significant correlations for all agencies were:

Nurse autonomy\patient autonomy was correlated at the .01 level of significance. Patient and familiarity was correlated at the .01 level of significance and organizational support\familiarity were correlated at the .01 level of significance.

For public health departments, the following correlation was obtained: Nurse autonomy\patient autonomy was correlated at the .01 level of significance.

For home health agencies, the following correlation was obtained: Nurse autonomy\patient autonomy was correlated at the .01 level of significance.

For hospices, nurse autonomy\patient autonomy was correlated at the .01 level of significance.

In the NDT, the third instrument, the following correlation was found for all agencies: Nursing principled\familiarity at the .05 level of significance.

For health departments, the correlations were nursing principled\familiarity at the .05 level of significance and nursing principled\practical considerations at the .01 level of significance.

There were no significant correlations for hospices.

This study does support a nursing advocacy model across all agencies with the correlation between patient autonomy and nurse autonomy. This raises many questions as to the origin of the relationship since many of the variables did not correlate with demographic data nor with nursing principled reasoning.

This and other conclusions related to the hypotheses will be explored in the following chapter.

CHAPTER V

FINDINGS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction

In this chapter a discussion of the findings reported in Chapter IV is presented. The findings are related to specific ethical findings of authors prominent in moral development studies. Observations and conclusions relevant to educational applications of ethical development are presented and recommendations for future research suggested.

Advocacy in this study was defined as "an ethical response of the nurse in actively assisting patients in their free self-determination of treatment options; to help individuals become clear about what they want in a situation, to assist them in discerning and clarifying their values and to help them examine options in light of their values.

The contention was made that there are specific factors which influence the need for advocacy within society. The first are factors which impinge upon the profession of nursing, e.g., legal standards, professional codes and standards, ethical standards and codes.

Nursing models and theories promote the use of advocacy, ethical education and development as interrelated entities. Nurses have been subjects in research that has examined the constructs of stage levels of development, learning theories, moral distress, patient autonomy, the work environment, and the role of education in ethical development.

In addition there are factors within society which influence the need for advocacy. These factors are demographic, sociocultural, economic, political and technological innovations. Since community health nurses operate within all these environments, it is important to understand how they conceptually organize and integrate these factors in

providing humane services to clients.

Direct patient advocacy (DPA) has been defined as a theoretical concept in this study. i.e., the type of individual relationship which supports patient and nurse autonomy as an ethical model.

In this study, the elements of cognitive development, education, social development, nurse autonomy, patient autonomy and moral reasoning/action were considered to have an influence upon an advocacy role for nurses.

Autonomy was considered to be the concept of self-governing, i.e., able to act in accord with a plan which had either freely chosen or at least had independently endorsed.

Several factors have been studied to determine the influences which contribute to direct patient advocacy. These influences were based upon demographic characteristics of the subjects, their nursing beliefs and practices based upon ethical standards and principles in the profession of nursing (patient autonomy, nurse autonomy and organizational support) and the degree to which nurses reasoned at a principled level of moral judgment.

The subjects were drawn from community health nursing agencies: public health departments, home health care agencies and hospices since there has been few studies that have examined this particular group of nurses. The importance of studying these individuals arose from the need to understand the various factors which govern or support ethical practice in community nursing, e.g., legal requirements, professional moral/ethical standards, ethical education, and how these factors relate to research on stages of ethical development.

The overall factors which were postulated as influential in the

use of professional autonomy and patient advocacy were:

1. Ethical education and experience in nursing.
2. The moral development of nurses.
3. Recognition that an ethical dilemma requiring action on the part of the nurse is present in the patient care situation.
4. The amount and type of agency support that nurses perceive is available to them as they provide nursing care in ethical dilemmas.
5. The degree of autonomy exercised or allowed the nurse in decision-making and patient advocacy interventions.
6. Encouragement of group participation and discussion which reflect on social and moral issues and conflicts to stimulate awareness of ethical concerns.
7. Orientation to the relationship of autonomy (both patient and nurse) as practiced within the agency, and
8. Establishment of a moral climate where individuals are expected to make ethical decisions, assume responsibility and accountability for their decision making.

Demographic Findings and Conclusions

Demographic characteristics of the subjects, age, basic educational preparation, current place of employment, length of experience in nursing, and formal educational experiences with an ethical component were explored (course, part of a course, clinical rotation and continuing education).

The null hypothesis H_{01} : There is no significant relationship between ethical judgment scores and age was accepted. Age does not have a significant correlation with ethical judgment scores. Conclusion: In

this study, ethical judgment was not influenced by the age of the nurse.

The null hypothesis H_{02} : There is no significant relationship between ethical judgment scores and the educational preparation of the nurse (baccalaureate, associate degree or diploma) was accepted. Educational preparation of the nurse does not have a significant correlation with ethical judgment scores. Conclusion: In this study, ethical judgment was not influenced by the basic educational level of the nurse.

The null hypothesis H_{03} : There is no significant relationship between ethical judgment scores and number of years employed in nursing was accepted. The number of years employed in nursing does not have a significant relationship with ethical judgment scores. Conclusion: In this study, ethical judgment was not influenced by the number of years that the nurse was employed in nursing.

The null hypothesis H_{04} : There is no significant relationship between ethical judgment scores and place of employment (health department, home health care or hospice) was accepted. The place of employment does not have a significant relationship with ethical judgment scores. Conclusion: In this study, ethical judgment was not influenced by the place of employment of the nurse.

The null hypothesis H_{05} : There is no significant relationship between ethical judgment scores and the length of time employed in a community nursing agency was accepted for health departments and hospices and rejected for home health agencies. Conclusion: In this study, ethical judgment was not influenced by the length of time employed in a health department or hospice, but was influenced by employment in a home health agency.

For home health agencies, experience was correlated with practical considerations which means that the nurse may elect to minimize or ignore the ethical aspects of care and concentrate on concerns such as, "do I have the time attend to the ethical concerns over the technical needs of the patient?" Practical considerations and experience had a correlation coefficient of .3885 at the .05 level of significance for home health care nurses only. Conclusion: In this study, practical considerations were influenced by employment in a home health agency.

Demographic Implications

The finding that years worked in nursing affects moral behavior has been previously reported in Crisham's (1979, p. 4212-B) and Nokes's (1985, p. 678-B) studies. Rest (1986, p. 18) has stated that as the costs of moral action come to be recognized, a person may distort the feelings of obligation by denying the need to act, denying personal responsibility, or appraising the situation as to make alternative actions more appropriate...i.e., they may defensively reappraise and alter their interpretation of the situation.

Although the finding that experience and practical considerations have been known to have this relationship, it is unclear why it was only observed in home health care agencies within this study. On the NABP, scores for organizational support would not indicate that the nurses felt a lack of support from supervisors.

Demographic Recommendations:

In the basic educational program, the ethical standards of the profession should be addressed on a consistent basis. First students should be aware of the standards and their importance in nursing practice. Secondly, in clinical areas of practice, case conferences

should address not only the physical and psychological but also the possibility that there are ethical concerns of practice in particular patient situations.

Agency philosophy and policies should contain a statement on the type of dilemmas and the importance of regular assessment of the ethical problems experienced by clients of home health agencies.

Orientation to the agency should emphasize that time is not a constraint on home visits. The nurse should believe that her visits can and should include the time necessary to explore the ethical implications in the care of the individuals.

Agency supervisors should encourage attention to ethical situations as well as the physical and psychological components of nursing care.

A review of nursing care plans within the agency should be undertaken to determine whether recording supports a physical care emphasis rather than an integration of psychological and ethical aspects of care.

Educational Hypotheses and Conclusions

The null hypothesis H_{06} : There is no significant relationship between ethical judgment scores and instruction in ethical principles and practices (i.e., course in ethics, part of a course, or part of a clinical experience) was accepted since there were no significant relationships between instruction and ethical judgment scores.

Conclusion: In this study, ethical judgment scores were not influenced by education in ethics.

The null hypothesis: H_{07} = There is no significant relationship between ethical judgment scores and amount of continuing education was

accepted. There were no significant relationships between ethical reasoning and attendance at workshops, staff development activities or conferences).

Educational Implications

Foremost in the implications within this study is that formal education is the foundation for introduction to the ethical standards of the profession. At best, for the majority of the subjects within this study, formal ethical education was not ensured as part of their program (59% did not have a course with ethical content in their basic education). Nurses within this study have a mean of 16 years of experience in nursing so their formal education does not represent what current graduates might obtain in their educational program.

It can be stated that only a small portion of individuals (31%) have engaged in continuing education experiences which have a component related to ethical concerns. Continuing education sessions attended by nurses are either selected by the nurse or the employing agency based upon whether the individual or the institution has an interest in a particular area. In the past, many agencies supported the continuing education of the nurse by paying for registration fees, but in recent years this source of funding has been restricted. Therefore the nurse must finance her own education and presently there is no requirement in Michigan for Continuing Education Units for licensing. Currently a regulation for requiring Continuing Education Credits for nurses is being developed by the State Board of Nursing.

Kohlberg (1976, p. 136) has stated that education is a crucial variable in the development of principled moral reasoning. Aroskar (1989, p. 973) contends that community health staff nurses confront a

variety of significant ethical problems in practice. These problems require the educational background to assist nurses in identifying ethical problems and to develop a process for resolving ethical dilemmas which take into account the autonomy of individuals.

Rest (1986, p. 176-78) states that well established findings in moral development are that moral judgment changes with time and formal education and this change is a developmental progression. In addition, he states that people who develop in moral judgment are more fulfilled in their career aspirations, have an interest in continued intellectual stimulation and challenge, and take more interest in larger societal issues.

Educational Recommendations

1. Educational effort cannot be the responsibility of educational institutions alone. If ethical education is not part of the individual's basic educational experience then efforts must be made to ensure that the employing agency is able and willing to extend additional educational opportunities to their employees. This is for the benefit of the nursing staff and patients alike.
2. An analysis of the ethical educational background of experienced nurses employed in the agency should be undertaken. If appropriate, orientation should be provided on the ethical implications of practice or the agency should provide a staff development program which clarifies the expectations of the agency in regard to the balance between the practical considerations of nursing care and the ethical considerations inherent in patient situations. (Note: Spradley (1985, p. 118)

has an ethical decision-making framework which would be suitable for an in-service).

3. Study the curriculum of current nursing programs to determine to what extent teaching about ethical concepts is currently being provided to students, where (i.e., in what teaching rotations, and courses) ethical teaching occurs and if ethical teaching is integrated throughout the curriculum.
4. Accreditation standards for nursing educational programs should ensure that the curriculum addresses the ethical standards of the professional and that not only courses be included, but also, instruction in clinical rotations to promote ethical instruction and practice which is relevant to the clinical setting.

Nursing Advocacy/Beliefs and Practices Findings and Conclusions

The null hypotheses: H_{08} : There is no significant relationship between nurses' beliefs about patient autonomy and ethical judgment scores was rejected. In the construct of nursing autonomy/patient autonomy the correlation coefficient was .5040 at the .01 level of significance across all agencies. For health departments the correlation was .6750 at the .01 level of significance. For home health care agencies the correlation was .5099 at the .01 level of significance and for hospices the correlation was .6045 at the .01 level of significance. Conclusion: In this study, the nurses beliefs about patient autonomy was influenced by ethical judgment.

The null hypothesis: H_{09} : There is no significant relationship between the nurse's perception of autonomy in decision making and ethical judgment scores was rejected. Conclusion: In this study, the

nurses perception of autonomy in practice was influenced by ethical judgment.

Nursing Advocacy/Beliefs and Practices Implications

Nurses who selected ethical standards of practice as a preference met the definition of autonomy used in this study, i.e., they are individuals who are self-determining and able to act in accord with a plan they have freely chosen or at least independently endorsed. The nurses in this study who made choices related to ethical practice also selected principles stated as patient's rights which indicated that when the nurse believes in autonomy within his\her practice, the patient is considered to be an autonomous person also.

Allebeck (1990) refers to autonomy as:

...a capacity for self-rule which is a quality inherent in rational beings that enables them to make reasoned choices and action based on a personal assessment of future possibilities evaluated in terms of their own value system. In this view, autonomy is a capacity that flows from the fact that humans can think and feel and make judgments about what seems to be good.

Items related to patient autonomy were based upon recognized ethical standards and principles e.g., truth-telling, autonomy, justice, confidentiality, fidelity, beneficence, non-maleficence and respect for persons and their inherent worth.

Ethical constructs which were measured in the category of nursing autonomy were: professional responsibility for planning patient care, accountability for promises made, access to care, establishing a partnership with the patient, confidentiality and respect for self-determination for patients.

Organizational Support Findings and Conclusions

The next finding related to organizational support and familiarity

with the situation. The correlation coefficient between organizational support and familiarity was .2846 at the .01 level of significance over all types of agencies. Therefore the null hypothesis H_{010} : There is no significant relationship between the nurses perception of agency support and familiarity with the ethical situation was rejected. Conclusion: In this study, nurses' perception of agency support was by influenced by familiarity with ethical judgment.

Organizational Support Implications

The instrument which measured organizational support included items which could be related to familiarity, such as, whether supervisory help was provided when the nurse was confronted with an ethical dilemma in practice, and whether supervisors stimulated thinking about dilemmas of practice or encouraged the use of new techniques in patient care.

Mayberry (1986, p. 78) has stated that the work place may strongly influence the individual's moral judgments and that even when decisions are based on a more reasoned approach, they may be made more difficult by factors that hamper their resolution, such as administrative policies and organizational structure. She also indicates that as nurses grow older and gain more experience, they become imbued with the organization's aim and develop loyalty to the institution and peers.

Crisham (1981, p. 104) has reported that previous deliberation about real life dilemmas appears to be associated with the way subjects judge morals as assessed by the NDT. Mahon (1979, p. 9) has suggested that transition from one stage of development is more likely to occur when a person is challenged with moral problems for which his stage of thinking provides no easy answers, and presented with responses a stage

higher than his own.

Recommendations for Employing Agencies

1. Provide opportunities for shared decision-making between individuals or groups when ethical problems are encountered to increase familiarity with ethical dilemmas and highlight ethical choices as opposed to practical considerations.
2. Provide supervisory encouragement and support to nurses who are dealing with difficult ethical problems to enhance their ability to select strategies which enhance the resolution of difficult dilemmas.
3. Provide monetary support for attendance at continuing education offerings related to ethics to reinforce familiarity with ethical concepts in nursing practice and help nurses to distinguish between ethical options in practice as opposed to practical considerations.
4. Community health nursing agencies should assess the educational needs of their nursing staff and provide orientation based on the three components of moral instruction recommended by Hersch (1980); caring, judging and acting.
5. An assessment should be made of the types of ethical dilemmas experienced by clients of the agency to determine what the educational needs of staff would be.
6. An orientation to the agency which focuses on the types of ethical dilemmas faced by clients of the agency should be developed (Example: access to care for public health departments, AIDS counseling; ethical considerations in death and dying for hospices and self-determination (autonomy) in

decision making for clients across all agencies).

7. Establish an ethics committee which would review decisions made and, in cases where ethical dilemmas have been identified, recommend changes in agency policy or procedures.
8. Quality assurance record reviews should focus on the degree to which nurses identify ethical concerns of patients and families and utilize opportunities to increase patient autonomy in decision making. When situations are found where there is evidence that ethical issues were well addressed or maybe overlooked, provide a case conference for staff nurses to illustrate by example the positive or negative consequences of dealing with an ethical dilemma.

Practical Considerations Findings and Conclusions

The null hypothesis H_{011} : There is no significant relationship between nursing principled reasoning and practical considerations was rejected. Over all types of agencies the correlation coefficient was $-.4355$ at the $.01$ level of significance. For health departments the correlation coefficient was $-.4403$ at the $.01$ level of significance and for home health care agencies, the correlation coefficient was $-.4921$ at the $.01$ level of significance. Conclusion: In this study, nursing principled reasoning was negatively influenced by practical considerations for health departments and home health care agencies, i.e., nurses who emphasize the importance of practical considerations tend to minimize or ignore the ethical implications of the patient's situation.

The null hypothesis H_{011} : There was no significant relationship between nursing principled reasoning and practical considerations was

accepted for hospices. Conclusion: In this study, nursing principled reasoning was not influenced by practical considerations.

Implications Derived from the Nursing Dilemma Test

In the NDT, although nurses were presented with dilemmas that were "real-life", i.e., taken from real nursing situations, the subjects were asked not what they would do, but what should the nurse do. This focus may tend to blur actual choices made since the nurse is not responding as if she were the person in the dilemma.

In the section of the NDT where the nurse was asked what action she would take, twenty-three percent were unable to decide on the action. The dilemma with the most agreement among the answers was related to reporting an error in administration of medication. Across the three types of agencies, 60-90% of the subjects indicated they would report the error. This may well relate more to risk management education since nurses are strongly urged to report medication errors because of the potential for legal liability rather than an ethical concern.

Crisham (1979, p. 110) reported that the more experienced nurses were, the more effective they were in confronting real-life or practical situations. Mayberry (1986, p. 77) states that nurses often use intuitive approaches to ethical problem solving which does not involve the process of critical inquiry. Rest (1986) suggests that subjects sometimes engage in defensive evaluations to deny or minimize feelings of moral obligation.

...As the costs of moral obligation come to be recognized, a person may distort the feelings of obligation by denying the need to act, denying personal responsibility, or appraising the situation as to make alternative actions more appropriate. In other words, as subjects recognize the implications ...and the personal costs of moral action become clear, they may

defensively reappraise and alter their interpretation of the situation. (p. 18)

Weiss (1982) reports that,

The philosopher Rawls has suggested that moral reasoning in real-life situations is less adequate than hypothetical moral reasoning, because in real life, moral reasoning is swayed by an awareness of personal needs that generally is not present when considering the hypothetical (p. 852).

Practical considerations are also referred to as prudential concerns. An individual may be concerned with "getting in trouble," "getting caught" or "being found out." Individuals who characteristically demonstrate moral reasoning at the highest structural levels can have also have these concerns (Damon, 1977, p. 89).

Nursing Principled Reasoning/Familiarity Findings and

Conclusions

The null hypothesis H_{012} : There is no significant relationship between principled reasoning and familiarity with the dilemmas was rejected over all agencies and for health departments. The hypothesis was accepted for home health care and hospices.

Across all agencies, patient autonomy and familiarity had a correlation coefficient of .2846 which was at the .01 level of significance. For health departments only the correlation coefficient was .2717 at the .05 level of significance. Conclusion: In this study the patient autonomy was influenced by familiarity with the dilemma for over all agencies and for health departments. For home health care and hospices, familiarity with the dilemmas was not influenced by nursing principled reasoning.

In associating nursing principled reasoning and familiarity with the dilemmas it is not clear what factors come into play to cause the

result. It could be speculated that principled reasoners learn from their practice as they apply strategies in ethical clinical situations and are able to cognitively process or translate their learning to subsequent ethical situations. It can be speculated that as nurses deal with situations which appear to have an element of "risk-taking" and they use strategies which seem to be effective, their reasoning skills are enhanced and they gain confidence.

Implications Related to Professional Associations

Allebeck (1990) has stated that,

The existence of the capacity for self-rule embedded in what it means to be a human being is that it constitutes a moral claim, a claim which generates a duty of respect in other persons. This claim is expressed as the principle of autonomy: i.e., to so act in relationships with others that their capacity for autonomy (and thus their moral claim) can be exercised as fully as circumstances permit (p.5).

The professional nursing associations; The American Nurse Association and The National League for nursing also have a role in the promotion of ethical practice. These associations have been active participants in formulating and promulgating ethical statements, standards for nursing care and legal requirements for nursing practice. Sigma Theta Tau, the national nursing honor society has promoted ethical practice as well. All three organizations publish a journal and feature articles on ethical problems, ethical education or research related to ethics.

Recommendations for Professional Nursing Organizations

1. Continue to promote ethical standards of nursing through review and revision of existing codes, and ethical statements as needed.

2. Continue to publish research articles and other articles which explore and explain the need for ethical practice, what constitutes ethical practice and how ethical practice can be implemented in the workplace.
3. Continue to publish articles with an ethical and research focus in their monthly journals (American Journal of Nursing, Nursing and Health Care and Image).
4. Support research which has an ethical focus through funding scholarship and research grants and publish information on national research and fellowship opportunities which have a focus upon nursing standards and ethical practice.
5. Sponsor workshops, conferences and seminars to promote ethical practice throughout nursing regardless of place of employment. Findings in ethical research have reported that as nurses become more experienced, they tend to make decisions based upon practical considerations.

Research Recommendations

1. Future research should be undertaken which is based upon nursing ethical dilemmas from an individual's own experience with an analysis of the decision-making employed and exploration of the reasoning involved in making the decision.
2. Research could be done to explore the type of strategies actually used by nurses in resolving ethical dilemmas and measuring which strategies are effective.
3. Replication of this study with a larger population from another section of the country should be done to verify the findings of this study.

4. Replication of the study to explore the construct of organizational support for ethical practice by trying to increase staff nurses familiarity with ethical dilemmas.

Summary

In this study several factors were studied to determine the influences which contribute to direct patient advocacy. These influences were based upon demographic characteristics of the subjects, their beliefs and practices based upon ethical standards and principles in the profession of nursing (patient autonomy, nurse autonomy and organizational support) and the relationship of nursing principled reasoning to factors such as familiarity with ethical dilemmas and the use of practical considerations in lieu of an ethical response.

The significant relationships reported across all agencies were:

1. Nursing autonomy\patient autonomy were significantly related to ethical judgment.
2. Patient autonomy\familiarity were significantly related to ethical judgment.
3. Organizational support\familiarity were significantly related to ethical judgment.
4. Nursing principled reasoning\practical considerations were significantly related with a negative correlation.

For health departments the significant relationships were:

1. Nursing autonomy\patient autonomy were significantly related to ethical judgment.
2. Nursing principled reasoning\practical considerations were significantly related with a negative correlation.
3. Nursing principled reasoning\familiarity were significantly

related.

For home care agencies the significant relationships were:

1. Nursing autonomy\patient autonomy were significantly related to ethical judgment.
2. Practical considerations\experience were significantly related.
3. Nursing principled reasoning\practical considerations were significantly related with a negative correlation.

For nurses employed in hospices, the only significant relationship was between nursing autonomy\patient autonomy and ethical judgment.

This study supports the contention that nursing advocacy is based upon autonomy of both the nurse and the patient, moral principled reasoning and familiarity are related and organizational support and familiarity are related.

The implications for professional associations, educational institutions and employing agencies have been described and recommendations have been made for further research, basic professional education and continuing education. Recommendations have been made for agency strategies for increasing awareness of the ethical dilemmas in the practice of nursing and assisting nurses to assume the role of an advocate so that patient would be treated as an autonomous individual capable of making decisions in their own best interest. Nursing care given should involve a nurse-patient partnership while patients are receiving care from community health agencies.

APPENDIX A

Appendix A

Personal Data

- A. Age in Years.....1. _____
- B. Sex.....2. () female
3. () male
- C. Basic Nursing Education.....4. () Diploma
5. () Associate Degree in Nursing
6. () Baccalaureate Degree in Nursing
7. () Other degrees (nursing or non-nursing)
Please list: _____

- D. Current place of employment.....8. () Public Health Agency
9. () Home Health Agency
10. () Hospice
- E. Number of years employed in nursing.....11. () _____
- F. Work Experience in Nursing (other than as a student).....Hospital
12. () 5 or more years
13. () 2-4 years
14. () 1-2 years
15. () none
Home Health Agency
16. () 5 or more years
17. () 2-4 years
18. () less than 2 years
19. () none
Public Health Agency
20. () 5 or more years
21. () 2-4 years
22. () less than 2 years
23. () none
Hospice
24. () 5 or more years
25. () 2-4 years
26. () less than 2 years
27. () none
- G. Have you had any formal coursework on the subject of ethics:
In a course?
28. () No
29. () Yes
If yes, Name of course _____
As part of a course?
30. () No
31. () Yes
If yes Name of course _____
As part of a clinical rotation?
32. () No
33. () Yes
If yes Name clinical area _____
- H. Have you had any teaching regarding ethics in any other educational experiences. i.e., workshops, staff development or continuing education courses?
34. () No
35. () Yes
If yes, Name of offering _____

APPENDIX B

NURSING ADVOCACY/BELIEFS AND PRACTICES

1 = Strongly agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly disagree

	1	2	3	4	5
1. Patients have the right to make their own choices.					
2. The agency policy supports the concept of patient's rights.					
3. As a professional, I make the decisions about the appropriate nursing care.					
4. Patients have a right to know their prognosis.					
5. Nurses should be held accountable for their promises to the patient.					
6. The nurse has a duty to protect the patient from harm regardless of which professional is involved in the care.					
7. The agency encourages and supports my continuing education needs.					
8. The nurse is responsible for patient safety.					
9. Teaching patients self-care increases their autonomy.					
10. As a nurse, I am responsible for my actions					
11. Patients should be able to refuse care.					
12. Patients have a right to information about their diagnosis.					
13. The cultural orientation of the patient should be respected even when it conflicts with your values.					
14. Nurses should tell the truth to patients.					
15. The nursing care plan is the nurse's responsibility.					
16. I have a responsibility to talk with the doctor when I feel that the patient's rights have not been considered.					
17. I know what is best for my patients.					
18. Nurses are autonomous agents, i.e., determine their own actions.					
19. Agency policies regarding the amount of time spent on a visit reduces the nurse's ability to address the ethical concerns of practice.					
20. The relationship of the nurse and the patient is a partnership.					
21. I am able to try new techniques with patients without getting permission from my supervisor.					
22. All persons should have equal access to care based upon potential benefit or need.					
23. The nurse should protect information shared by the patient.					

1 = Strongly agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly disagree

- 24. Nurses have an obligation to ensure that their knowledge base is current and accurate.
- 25. Supervisors in the agency stimulate thinking about dilemmas of practice.
- 26. Supervisors encourage and support my continuing education needs.
- 27. The agency provides help when I am dealing with an ethical dilemma in my practice.
- 28. Supervisors encourage my use of new techniques in patient care without the need for permission.

1	2	3	4	5

APPENDIX C

Appendix C
Nursing Dilemma Test (Sample)

**Example of Terminally Ill Adult Dilemma in the
Nursing Dilemma Test**

Following exploratory surgery, a 48-year-old man was diagnosed as having inoperable lung cancer. The physician informed the patient and his family of the operative findings shortly after surgery when the patient was not fully alert. A few days later the patient repeatedly asked questions about his health. His lack of knowledge of the diagnosis was evident. The family asked that the patient not be told of his condition. The physician decided to respect the family's request and wrote an order not to discuss the diagnosis with the patient. The nurse wondered whether to respect the wishes of the family and the physician or to answer the patient's questions.

- A. What should the nurse do? Check one response.
Should answer the patient's questions _____
Can't decide _____
Should not answer the patient's questions _____

- B. The nurse considers the following six issues:
1. How can I best follow the specifications on sharing information in the patient's Bill of Rights?
 2. Is the physician on the unit during times when it would be possible to discuss this?
 3. Are the wishes of the patient's family most important because the family is closest to the patient?
 4. Would I be meeting the fair expectations of the patient and his family?
 5. Could the family and the physician do anything to me for answering the patient's questions?
 6. Does the patient in his own case have the right to decide about who should know the diagnosis?

From the list of considerations above, select the one that is the most important. Put the number of the most important considerations on the top left line below. Do likewise for your 2nd, 3rd, 4th, 5th, and 6th most important considerations.

Most Important _____	Fourth Most Important _____
Second Most Important _____	Fifth Most Important _____
Third Most Important _____	Sixth Most Important _____

- C. Have you encountered a similar dilemma? Indicate your previous degree of involvement with a similar dilemma using one of the following choices.

- 1 = Made a decision in a similar dilemma.
- 2 = Knew someone else in a similar dilemma.
- 3 = Not known anyone in a similar dilemma, but dilemma is conceivable.
- 4 = Difficult to imagine the dilemma as it seems remote.
- 5 = Difficult to take the dilemma seriously as it seems unreal.

Check one response: 1 2 3 4 5

Source: Crisham, P. (1981). Measuring moral judgment in nursing dilemmas. Nursing Research, 30(2), 170.

APPENDIX D

APPENDIX D

Definitions

Autonomy - individuals are autonomous to the extent that they are self-determining or able to act in accord with a plan they had either freely chosen or at least independently endorsed.¹ (synonym: self-governing).

Beneficence - do good or at least do no harm.²

Confidentiality - classified, private, restricted, secret, undisclosed.³

Community Health Nursing -- a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. Therefore, nursing directed to individuals, families or groups contributes to the health of the total population. Health promotion, health maintenance, health education, coordination and continuity of care are utilized in a holistic approach to the family, group and community.⁴

Thus the nurse must become familiar with the moral requirements of the practice of nursing in general and the practice of community health nursing in particular.⁵

...Community health nursing practice, as a composite of the individualistic ethic of nursing and the aggregate ethic of public health, is ..responsive to the moral requirements of ethical principles as prioritized within these ethics.⁶

¹Benjamin, M. & Curtis, J. (1981). Ethics in Nursing. New York: Oxford University Press, 21.

²Thompson, J. E. & Thompson, H. O. (1985). Bioethical Decision Making for Nurses. Norwalk, CN: Appleton-Century-Crofts, 218.

³Wordperfect (1989), Thesaurus.

⁴American Nurses' Association (1973). Standards of Community Health Nursing Practice. Kansas City: ANA Publications CH-2 5M). unnumbered pages.

⁵American Public Health Association, Public Health Nursing Section: (1980) The Definition and Role of Public Health Nursing in the Delivery of Health Care. Washington, D. C.: APHA, 4.

⁶Stanhope, M. & Lancaster, J. (1984). Community Health Nursing: Process and Practice for Promoting Health. St. Louis: The C. V. Mosby Company, 95.

Ethical dilemma - involves a choice between equally unsatisfactory alternatives of a difficult problem that seems to have no satisfactory solution.⁷

Fidelity -strict observance of promises, duties (allegiance, faithfulness, devotion, loyalty).⁸

Justice - equity, fairness, right, truth⁹

Justice, distributive - the allocation of scarce resources; equity.¹⁰

Moral judgment - decision, verdict, or conclusion about a particular action or character trait. Judgments or decisions are justified by moral rules (the oughts, ought nots).

Example: It is wrong to deceive patients. Deception violates the principle of autonomy.¹¹

Moral reasoning - a cognitive and developmental process characterized by a sequential transformation of the way in which social arrangements are interpreted.¹²

Non-maleficence - do not harm, usually paired with do good. (Appears in the Hippocratic Oath, which urges health care professionals to do good or at least do not harm.¹³

Paternalism - Latin pater means "father." Describes tendency of health care workers to treat patients as though they are children. (This parental attitude may violate informed consent and the autonomy of the patient.)¹⁴

⁷Stanhope, M. & Lancaster, J. (1984). Community Health Nursing. St. Louis: The C.V. Mosby Company, 95.

⁸Wordperfect, Thesaurus.

⁹Wordperfect, Thesaurus.

¹⁰Thompson, 222.

¹¹Beauchamp, T. L. & Walters, L. Contemporary Issues in Bioethics. Belmont, CA: Wadsworth Publishing Company, Inc. 139.

¹²Ketefian, S. (1989). Moral reasoning and ethical practice in nursing. Nursing Clinics of North America, 24(2). 510.

¹³Thompson, 229.

¹⁴Thompson, 229.

Patient advocacy - actively assisting patients in their free self-determination of treatment options; to help individuals become clear about what they want in a situation, to assist them in discerning and clarifying their values, and to help them in examining options in the light of their values.¹⁵

Principal - an accepted or professional rule of action or conduct; a guiding sense of the requirements and obligations of right conduct.¹⁶

Principle - The English comes from the Latin for "beginning." It is the origin or cause or basic truth or doctrine. Ethical principles are basic reasons.¹⁷

Public health nursing - synthesizes the body of knowledge from the public health sciences and professional nursing theories. The implicit overriding goal is to improve the health of the community by identifying populations which are at high risk of illness, disability, or premature death and directing resources toward these groups.¹⁸

Veracity - accuracy, truth,¹⁹

¹⁵Gadow, S. (1981). Advocacy: An ethical model for assisting patients with treatment decisions. In E. B. Wong & J. Swazey (Eds.). Dilemmas of Dying. Boston: G. K. Hall Medical Publishers, 136.

¹⁶Thompson, 229.

¹⁷Thompson, 229.

¹⁸Public Health Nursing Section, American Public Health Association. (1980). The definition and role of public health nursing in the delivery of health care. APHA Newsletter, June, 2.

¹⁹Wordperfect, Thesaurus.

APPENDIX E

Appendix E

July 5, 1990

Dear ,

The purpose of this letter is to explore the possibility of including nurses within your agency in a study of ethical dilemmas in nursing practice.

This research study will explore nurses' responses to actual ethical dilemmas experienced in practice with selected factors, such as, age, experience, education, and type of employment (public health, hospice or home health care). A second phase of the study will explore how these nurses perceive patient autonomy, nurse autonomy and organizational factors in practicing patient advocacy. The amount of time necessary to complete these documents should be approximately 30-40 minutes.

All information supplied by the nurses in this study will be coded to remove the possibility of identification with the agency or individual nurses. Participants will receive a letter explaining the intention and procedures of this research study. Your agency was randomly selected from a list of community health agencies. The nurses to be included in the study will be selected by random sample also. Confidentiality will be assured to all agencies and to all nurses involved in the study.

As a doctoral candidate in Adult and Continuing Education, College of Education at Michigan State University, I am conducting this study for my Ph.D. dissertation. I am a nurse with 20 years in community health nursing both in public health nursing practice and teaching baccalaureate students in public health clinical experiences.

If you give approval for staff nurses' involvement in this study, I would need a list of full time staff members who may be contacted individually by letter. I would share a summary of the final report of the study with you, if requested.

This study could contribute to an understanding of how nurses respond to ethical issues or dilemmas in their practice and could be of value to you in understanding the level of moral judgment exercised by nurses in community health practice. This may lead to further understanding of how nurses perceive their role as they work with patients and families in their homes.

Sincerely yours,

Patricia G. Hatfield, M. P. H., R.N.

APPENDIX F

APPENDIX F

August 16, 1990

Dear ,

You are invited to participate in a study of ethical dilemmas, autonomy and advocacy in nursing practice. This study has two major phases. The first phase is concerned with responding to moral dilemmas experienced by practicing nurses. The second phase involves responding to statements regarding ethical principles and patient/nurse autonomy. Your name was randomly selected from a list of community health nurses (public health, home care, hospice).

If you decide to participate, you will be given three documents to complete. The first will ask for information about you, your education, and experience. The second document contains six nursing dilemmas and issue statements for each dilemma which you will rate and rank according to their importance. You also will be asked about your familiarity with similar situations. In the third document, you will rank your response to each of 28 statements about patients, nursing practice and organizational practices.

The amount of time needed to complete these documents should be 30-40 minutes. You may complete these documents when convenient to you, but, if at all possible please return within two weeks.

Confidentiality will be assured. All records with any reference to you will be solely in the hands of the researcher. All tests are coded to remove possibility of identification or any connection with individual nurses. No names of any community agencies or nurses will be used in reports of this study.

Your decision whether or not to participate will not prejudice your future relations with your agency. If you decide to participate, you are free to discontinue participation at any time without prejudice. You indicate your voluntary agreement to participate by completing and returning the questionnaires.

If you have any questions, please contact me. My telephone number is 517-349-5015.

Thank you for considering this invitation. With this study, it will be possible to learn about how community health nurses think in responding to dilemmas in their practice. Your helpfulness, therefore is greatly valued.

Sincerely yours,

Patricia G. Hatfield, R. N., M.P.H.

APPENDIX G



UNIVERSITY OF MINNESOTA
TWIN CITIES

School of Nursing
6-101 Unit F
308 Harvard Street
Minneapolis, Minnesota 55455
(612) 624-9600

November 14, 1989

Ms. Patricia Hatfield
2055 Hamilton Road
Okemos, MI 48864

Dear Ms. Hatfield:

Thank you for your comments about the Nursing Dilemma Test. One of the benefits of that Nursing Research article is the opportunity to come to know others who share a similar research interest. I am happy to share the Nursing Dilemma Test--you use it with my permission. My request is that you send a summary of your findings so that we may continue to gather data on the Test.

As you know from the March-April Nursing Research article, there are three Nursing Dilemma scores you may want to use: Nursing Principled Thinking (NP); Practical Considerations (PC); Familiarity (F). In the NDT rankings, the item ranked as most important with each dilemma was given 6 points, the item ranked second was given 5 points, the item ranked third was given 4 points, the item ranked fourth was given 3 points, the item ranked fifth was given 2 points, and the item ranked sixth was given 1 point. The NP score was calculated by adding the scores of the NP items across the six dilemmas. The NP index represents the sum of weighted ranks given to principled items and is interpreted as the relative importance given to Principled moral considerations in making a nursing moral decision. The highest possible NP score is 66 with 2 NP items for each dilemma.

The relative importance given to practical considerations was indexed in a similar process. The PC score was calculated by adding the scores of items that represented Practical Considerations across the six dilemmas. The PC index represents the sum of weighted ranks given to Practical Considerations and is interpreted as the relative importance given to Practical Considerations in making a nursing moral decision. The highest possible PC score is 36 with 1 PC item for each dilemma.

You may be interested in obtaining a similar score for Stage 2, Stage 3, or Stage 4 thinking. You may also be interested in examining the subject's action choice in Part A of the Test.

Ms. Patricia Hatfield
November 14, 1989
Page Two

To measure the subject's degree of previous involvement with a similar dilemma, a Likert-type scale was used with each dilemma. On this five-point scale, "1" indicated, "Made a decision in a similar dilemma"; "2" indicated "Knew someone else in a similar dilemma"; "3" indicated, "Not known any one in a similar dilemma but dilemma is conceivable"; "4" indicated, "Difficult to imagine the dilemma as it seems remote"; and "5" indicated "Difficult to take the dilemma seriously as it seems unreal". The Familiarity (F) score was calculated by adding the points that indicated the subject's degree of previous involvement with similar dilemmas across the six dilemmas. The F index represents the sum of the subject's indication of degree of involvement with similar dilemmas. The classification of the subject as familiar or unfamiliar with the dilemmas was based on the properties of the F scale; a score of 6 through 17 indicated familiar with the dilemmas, and a score of 18 through 30 indicated unfamiliar with dilemmas.

With the enclosed Test and Key, my hope is that you have the information you need. My Ph.D. Thesis, "Moral Judgment in Nurses in Hypothetical and Nursing Dilemmas, "University of Minnesota, August 1979, may also be of help.

My best wishes to you in your research and work in this important area of ethical issues in nursing.

Sincerely,



Patricia Crisham, R.N., Ph.D.
Associate Professor

PC:j1
Enclosure

APPENDIX H

Appendix H

Years and Places of Employment

	Health Dept. N=55	HHC N=37	Hospice N=19
<u>Hospital</u>			
5+ years	30	24	8
2-4 yrs	20	10	7
Less than 2 yrs.	4	3	4
None	-	-	-
<u>Health Dept.</u>			1
5+ years	31	-	-
2-4 yrs	9	2	1
Less than 2 yrs.	14	7	-
None	-	34	17
<u>Home Health Care</u>			
5+ years	4	13	3
2-4 yrs	2	14	2
Less than 2 yrs.	9	10	1
None	15	-	12
<u>Hospice</u>			
5+ years	-	1	3
2-4 yrs	1	1	6
Less than 2 yrs.	-	3	11
None	53	32	-

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