

1993

## The effect of a semester unit of study on ethical issues in nursing on a group of practising registered nurses

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**THE EFFECT OF A SEMESTER UNIT OF STUDY ON  
ETHICAL ISSUES IN NURSING ON A GROUP OF  
PRACTISING REGISTERED NURSES**

by

**E.C. Ambrose RN**

**A Thesis Submitted in Fulfillment of the Requirements for  
the Award of  
Bachelor of Nursing (Honours)  
at The School of Nursing,  
Edith Cowan University, Western Australia.**

**Date of Submission: July 1993**

## USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

## ABSTRACT

This study explored the effect an educational unit on ethical issues in nursing had on the ethical reasoning of practising registered nurses. The educational unit was conducted at a university school of nursing as part of a baccalaureate degree programme for already registered and practising nurses.

A quasi-experimental posttest design utilising stratified random samples compared subjects from one group who had undertaken the unit ( $n=53$ ) with subjects from another group who had not ( $n=61$ ). Ethical reasoning was measured using Crisham's Nursing Dilemma Test and a researcher designed demographic data sheet provided information on additional variables for analysis.

The group which had undertaken the unit had a significantly higher principled thinking score at  $p=.05$ . There were no other significant findings for other variables. The result is discussed in relation to other research findings, various extraneous variables and theoretical and measurement issues.

## DECLARATION

"I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text."

Edward Ambrose

July 1993

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background

In the nursing literature ethical decision making is generally accepted by the nursing profession as being integral to nursing practice. However, a widely expressed view is that nurses are unprepared for making these decisions. As will be discussed later, historical factors have excluded nurses from involvement in the ethical arena, an exclusion which is keenly felt by nurses.

Making ethical decisions requires a relatively sophisticated grasp of what ethics is and of the ethical implications of any particular issue. For nurses, ethical knowledge may best be acquired during university level education. An educational unit dedicated solely to the study of ethical issues in nursing was started at a university school of nursing for the first time in the state of Western Australia in February, 1992. This study sought to investigate the effects of that study unit on the ethical reasoning of practising registered nurses.

## 1.2 Purpose of the Study

The present study sought to describe the effect an educational unit devoted to ethical issues in nursing, and conducted at a university school of nursing, had on the ethical reasoning of practising Registered Nurses. This study did not seek to measure ethical behaviour, but rather the reasoning process that informs any decision about action.

## 1.3 Significance of the Study

The ability to make ethical judgements is a necessary prerequisite for ethical decision making and action (Kohlberg, Levine & Hower, 1983). There is little published research into the effects of formal ethics education on the ethical judgement of practising nurses either overseas or in Australia. This study sought to determine if a unit designed and accredited at the university level of education could better prepare practising nurses to reason ethically and to make ethical judgements.

Such preparation may encourage an increasing involvement by nurses in the process of ethical decision making. As the health team professional whose role encompasses the overall care of the client at the physical, psycho-emotional and social levels the nurse makes decisions in everyday practice which involve ethical considerations.

The nurse's role as client advocate requires him or her to be involved in the process of ethical decision making. The ability to make reasoned ethical judgements is an essential requirement of nursing practice.

#### 1.4 Research Questions

##### 1.4.1 Principal Research Question

Was there a difference in ethical reasoning between practising registered nurses who had completed the unit dedicated to ethical issues in nursing and registered nurses who had not undertaken the unit?

##### 1.4.2 Subsidiary Research Question

Was there a relationship between the ethical reasoning of practising registered nurses and any of the variables; initial registration qualification, length of experience, previous exposure to education in ethics, completion of a unit of study in legal and ethical issues in nursing, age, position in the programme, principal area of experience?

## 1.5 Operational Definitions

### 1.5.1 The Dependent Variables

The dependent variables in this study were two scales from the Nursing Dilemma Test (NDT), namely Nursing Principled Thinking (NP) and Practical Considerations (PC). These were defined by Crisham (1981) as follows:

Nursing Principled Thinking (NP): "is interpreted as the relative importance given to principled moral considerations in making a nursing moral decision" (p. 107-8).

Practical Considerations (PC): "is interpreted as the relative importance given to practical considerations in making a nursing moral decision" (p. 108).

### 1.5.2 The Independent Variable

The independent variable was the study unit "Ethical Issues in Nursing" undertaken at a university school of nursing in the first semester of academic year 1992.

### 1.5.3 Additional Variables

Seven variables which may have influenced the ethical reasoning of the subjects of this study were identified. These were titled initial registration qualification, length of experience, previous exposure to education in ethics, completion of a unit of study in legal and

ethical issues in nursing, age, the number of units of the study programme completed and principal area of experience. These variables are discussed on p. 39 and are defined as follows:

Initial Registration Qualification: The qualification which allowed initial registration as a registered nurse.

Length of experience: The number of years worked as a registered nurse at one half full time employment or greater.

Previous exposure to education in ethics: Attendance at any session or series of sessions of greater than one day's duration exclusively devoted to the study of ethics or ethical and moral issues. Three categories were considered; no previous exposure, informal or non-certified exposure (for example inservice study days, seminars, conferences, summer schools) and formal (certified) exposure (for example accredited units at a tertiary institution such as the unit under investigation).

Completion of a unit of study in legal and ethical issues in nursing at university level: The accredited completion of a (previously mandatory) unit of study on legal and ethical issues in nursing at the participating university.

Age: Age was measured in years at last birthday.

Position in programme: The number of units of the degree course for registered nurses completed at the time of completing the questionnaire.



Area of major experience in nursing: This was defined as being in one of the following categories:

Chronic Care, where nurses' relationships with clients tend to be developed over time because of repeated or long term admissions. This category included such areas as general medical, haematology and oncology, palliative care, gerontology, community and psychiatric.

Acute Care, where nurses' relationships with clients tend to be developed over relatively short periods of time because of short or singular admissions. This included such areas as surgical, midwifery and critical care (emergency, intensive and coronary care).

Clinical Support, where nurses' relationships tend to be predominantly with other nurses rather than health clients. This included such areas as administration, staff development and education, and infection control. Data from an "other" category was allocated to one of the above three categories by the researcher.

## CHAPTER TWO

### CONCEPTUAL FRAMEWORK

#### 2.1 Definitions

The following definitions will be used in the discussion of the conceptual framework:

Cognitive dissonance "a state of conflict and discomfort occurring when existing beliefs or assumptions are challenged or contradicted by new evidence" (Goldenson, 1984, p. 154).

Moral (ethical) dilemma "a situation in which one is confronted with two or more choices such that selecting one violates one set of moral precepts and selecting the other violates another " (Reber, 1985, p. 201).

Moral (ethical) development "the gradual development of an individual's concepts of right and wrong" (Goldenson, 1984, p. 468).

Moral (Ethical) Judgement (Reasoning) "the beliefs an individual applies in discriminating between right and wrong; the attitudes that comprise a person's moral orientation whether or not they govern behaviour in each situation" (Goldenson, 1984, p. 469).

#### 2.2 Kohlberg's Theory of Moral Development

The conceptual framework for this study is Kohlberg's theory of moral judgement development. The instrument

used in this study to measure ethical reasoning was designed around this theory and it used a Kohlbergian based instrument as its prototype. Cassidy (1991) and Ketefian (1989b) report that Kohlberg's theory is the conceptual basis for most studies of ethical reasoning undertaken by nurses.

The basis of Kohlberg's idea of morality is the notion of justice, incorporating ideas of rights, reciprocity, equality and individual autonomy. The application of this morality requires a respect for and the fair application of rules. Kohlberg assumed that there is a core of universally accepted values which transcend culture and gender. He suggested that these values are based on ideas of punishment, property, roles and concerns of affection, roles and concerns of authority, law, life, liberty, distribution of justice, truth, and sex. These ideas directed Kohlberg's approach to the study of moral development allowing for a cognitive, rational approach to morality where objective reasons, or justifications, are distinguished from subjective decisions of personal commitment or allegiance. They also gave the greatest scope for structural analysis in the tradition of Piaget (Kohlberg et al., 1983; Duska & Whelan, 1977).

The theory postulates that moral judgement develops through a series of cognitive reorganisations, identifiable as stages. Each stage forms an organised system of thinking by which a person tries to reason

consistently. A person advances through the stages in an invariant sequence with each higher stage incorporating the reasoning in all preceding stages. A person is stimulated to go beyond his or her existing stage of ethical reasoning when confronted with an ethical dilemma which cannot be resolved within the prevailing ethical framework. The unresolved dilemma brings about the state of mind known as "cognitive dissonance" and the individual seeks a cognitively more satisfying solution or framework to encompass the ethical difficulty. Without this stimulus there is no reason to expect a person to advance to a higher stage of ethical reasoning. In this way, experience contributes to the movement to higher levels of ethical reasoning. A supportive, formal educational environment is considered one of the crucial factors in this development. (Rest, 1986; Kohlberg et al., 1983; Duska & Whelan 1977).

There are six basic stages in Kohlberg's hierarchy distributed across three levels of moral development. Each level describes the underlying principle on which behaviour is based. Each stage describes the individual's reasoning in deciding on what action to take. A brief description of Kohlberg's Levels and Stages can be found in Appendix A.

### 2.3 Support for Kohlberg's Approach

Kohlberg et al. (1983) report support for the theory from research which has used the Moral Judgement Interview (MJl). The MJl was developed by Kohlberg to explore and validate his work. The MJl uses short stories or scenarios of hypothetical ethical dilemmas to elicit responses from subjects. The dilemmas are of a general nature, that is they are not related to a special field and do not require special knowledge to be understood. The MJl however requires intensive training of an interviewer in order to both administer the test (by interview) and score the result (Ketefian, 1989b).

Further general support for Kohlberg's theory has come from studies using the Defining Issues Test (Duckett et al., 1992; Rest, 1986). Rest (1979) devised a standardised, objective measure of ethical reasoning as described by Kohlberg. Using both the hypothetical dilemmas from the MJl and the findings of studies which used the MJl to measure ethical reasoning Rest (1979) formulated the DIT. This is a multiple choice, self-administered, objective test which seeks subjects responses to six hypothetical ethical dilemmas. For each of these dilemmas subjects are asked to rate and rank a number of given items which reflect different ways of considering critical ethical issues. The DIT provides a standardised test with minimal dependency on verbal expressiveness and little effect from repeat testing.

Test-retest correlations averaging in the .80s and Cronbach alphas in the .70 to .80 range have been reported for the DIT (Duckett et al., 1992).

Conclusions drawn from the findings of over 1000 studies which have used the DIT include:

Moral reasoning progresses developmentally with time and formal education, the latter the stronger correlate.

Moral development is fostered by increased awareness of the wider social world, and is stronger among those who seek learning, challenge, and intellectual stimulation.

Moral education programmes need to be longer than three weeks duration for significant results to be obtained.

In cross cultural studies similarities are more pronounced than differences.

No significant gender differences have been found.

Moral reasoning influences moral behaviour.

(Duckett et al., 1992; Rest, 1986).

#### 2.4 Critics of Kohlberg's Theory

Kohlberg's Theory has not been without its critics. As Bloom (1986) observed there have been criticisms concerning bias specific to Western thought, liberal theory, male experience and individualistic political culture, which have raised both philosophical and methodological concerns. Critics view Kohlberg's construct as biased by a western cultural outlook and argue against Kohlberg's claims of universality and

implied moral absolutes (Bloom, 1986; Kohlberg et al., 1983).

Some nurses see a significant challenge from Gilligan's (1977, 1982) writings on an ethic of care, incorporating ideas of empathy, context, and concern for consequences which she found predominantly but not exclusively among women. A number of nurse authors have suggested that this may form the beginnings of a new paradigm for nursing (Cooper, 1989; Huggins & Scalzi 1988; Nokes 1989). Cassidy (1991) however, has urged caution in assuming that Gilligan's ideas can provide a sufficient framework for moral deliberation. Gillon (1992) goes further in discussing misinterpretations of "alleged moral incompatibilities between male and female ethics [and] between nursing and medical ethics". (p. 171). Gillon stresses that "Gilligan is describing a developmental process that differs between men and women, involving a fundamental difference in their starting perspective on morality.... [and that] ... as men and women mature, they increasingly come to appreciate the importance of both perspectives" (p. 172, emphasis in original).

## 2.5 Summary

While it is beyond the scope of this study to enter into the debate on Kohlberg's theory, it is still considered the best conceptual framework for a study on ethical

reasoning. Firstly, many critics tend to accept the major elements of Kohlberg's work as valid, questioning rather the scope of Kohlberg's theory. These generally seek to enlarge the domain of the theory. (Bloom, 1986; Gilligan, 1982; Hinman, 1985). Secondly, there is much to support the major components of Kohlberg's work (Bloom, 1986; Kohlberg et al., 1983; Rest, 1986). Thirdly, there is no adequately developed theory incorporating the major criticisms to replace Kohlberg's (Duckett et al., 1992). Fourthly, Kohlberg's is the most widely used conceptual framework for studying ethical reasoning, especially among nurses (Cassidy, 1991; Frisch, 1987; Ketefian, 1989b; Omery, 1983) and "the use of Kohlberg's theory as a framework from which to observe moral growth of nursing students allows for comparison of the current study population and previous work with nurses" (Frisch, 1987, p. 329).



## CHAPTER THREE

### REVIEW OF THE LITERATURE

#### 3.1 Ethics and Nursing

##### 3.1.1 What Ethics Is About

The literature reflects differing usage of the terms "moral" and "ethical". Gerald Winslow (1989) states that ethics "has to do with the systematic study of the things we value - the things we have reasons to want.... a careful reflection on the way we ought to share our lives." (p. 4). He goes on to say that it is also "the business of seeking and giving reasons for prescriptions and for prohibitions, for the things we value or disvalue" (p. 5). According to Reber (1985) "all of the subtle nuances in the meaning of this term [moral] focus on the central notion of pertaining to considerations of right and wrong conduct" (p. 450). Johnstone (1989) cites Ladd in pointing out that there are no significant philosophical differences between the two sets of terms. For the purposes of this study the words "ethical" and "moral" and derivative terms are considered synonymous.

##### 3.1.2 Nursing and Ethics

When ethics is mentioned in connection with nursing there may be a tendency to think of life and death issues. Such

ethical problems include the not for resuscitation order written in the patient's notes by the physician, how to treat a malformed neonate or the person in a persistent vegetative state, or how to respond to a person's request to be assisted to die. These are ethical problems that many nurses have had to or may have to face.

However, ethics pervades nursing in more and different ways than may be suggested by the consideration of issues such as these. It may be possible to avoid circumstances involving life and death by not working in certain areas, or by leaving a particularly onerous decision for others to make. As Fairburn (1987) has observed, there is a multitude of less dramatic decisions and actions taken each day by nurses which cannot be avoided and which may well pose ethical difficulties. Everyday and seemingly innocuous nursing duties may result in the transgression of ethical principles. Attending to the hygiene needs of a patient, for example, may violate the individual's autonomy. In institutions where nursing care is implemented according to a task oriented schedule, as in showering all patients before breakfast or insisting on daily showers at prescribed times, there may be a considerable degree of coercion or manipulation to have the patients conform with the institution's rules and norms. Different ethical principles may be violated through administrative decisions or procedures. For example, staffing levels are often determined on the basis of statistical averages. When allowances are not

made for periodic increases in patient acuity levels staffing may become inadequate to meet the needs of all patients. In this event the duty of care and the principle of justice may both be violated. The nurse carer must decide which patients and what needs take precedence with the full realisation that some will not be attended to.

### 3.1.3 Nurses and Ethical Decision Making

Given the intimate link between nursing actions and ethics it is noteworthy that a number of nursing authors have expressed the view that nurses are not adequately prepared for making ethical decisions. Omery (1989), for example, suggested that nurses may lack an understanding of the theories and concepts that form the domain of ethics. Cassels and Redman (1989), and Slater (1987) discussed the various pressures and constraints on nurses when they may attempt to deal with an ethical problem, and the lack of input they have in ethical decision making.

This is not to say nurses dismiss ethics as irrelevant to their practice. Cameron (1986) discussed the intimate link between stress and the ethical problems occurring in the workplace, citing a number of researchers, and Martin (1989, 1990) found "ethical anguish" in studies involving nurses in neonatal intensive care units and those working

with sufferers of AIDS (Acquired Immune Deficiency Syndrome).

#### 3.1.4 Nurses and the Ethical Domain

Historically, nurses have not been expected to contribute to the ethical domain. Whether in the public arena or in the consideration of more private and individual matters, such as removal of life support measures, the trend has been for nurses to be excluded from involvement in the consideration and resolution of ethical issues.

Johnstone (1989) has given some recent instances of the ways nurses are so excluded. These range from a situation where a physician openly asserted that nurses are incapable of sound rational thought or ethical thinking, to mass media reporting which has trivialised or ignored nursing contributions to or concerns about ethically contentious issues, and to law court decisions which have minimised or ignored the professionally accepted ethical standards of nurses. Other authors have also given past and contemporary examples of the myriad ways nurses are kept out of the ethical arena (Andersen, 1990; Bowman, 1990; Ketefian, 1984; Swider et al., 1984; Yarling & McElmurry, 1986).

### 3.1.5 Historical Factors and Nursing Education

This exclusion from the ethical domain is probably a consequence of a number of interwoven factors originating with the foundation of modern nursing in the latter part of the 19th century. Despite the views of those like Florence Nightingale that nursing education and practice should be controlled by nurses and that nursing was a separate entity from medicine (Johnstone, 1989), others, principally doctors, came to exercise authority over the nursing profession. Beginning nurses were educated by institutions which not only provided theoretical and practical training under the direction of physicians, but also employed them to undertake nursing duties and, after a specified period, certified their competence. Nurses were trained in an apprenticeship system based on skill acquisition and conformity to institutional rules (Ashley, 1976; Johnstone, 1987; Maggs, 1983, 1987). Nurses were dependent both on the institution and the physician for their livelihood, their education, and their identity as nurses.

This style of nurse education has predominated until recent times. Associated with this form of education was a model of professional ethics based on the virtue of the individual nurse and characterised by loyalty, duty, subservience and obedience. The teaching of nursing ethics centred on these characteristics, and the

inculcation of sets of rules to be applied in particular, defined circumstances (Ashley, 1976; Omery, 1983; Yarling & McElmurry, 1986).

These factors have moulded the culture and the profession of nursing as it has evolved since the late nineteenth century. It is these factors which have contributed to both the unpreparedness of nurses to be involved in ethical decision making and the distress they feel in being excluded. The alternative form of nursing education, the professional tertiary model, has slowly become widespread in North America over the last five decades, and in Australia only over the last ten years. Certainly in Australia, if not also North America, most practising nurses, and nurse leaders, have been educated and encultured by the older apprenticeship form of education.

### 3.1.6 Teaching Ethics

Ethics is a complex discipline of study. Western ethical thought is an amalgam of philosophic and religious speculation that has a written tradition of at least two and a half millennia incorporating numerous schools and sub-schools of thought. Traditional philosophic approaches based on considerations of duty (deontology) or consequences (teleology) have been challenged by controversial ideas from sciences such as biology and psychology (Rose, Lewontin & Kamin, 1984; Gould, 1977;

Likona, 1976) and social movements such as feminism (Johnstone, 1989).

Articles written by nurses for nurses exemplify the complexity of the discipline. Fowler (1989), for example, discusses metaethics and normative ethics, casuistic and analytical models of ethics, and the principles justice, autonomy, nonmaleficence and beneficence. Evans (1986) considers the teaching of ethics to nurses and discusses role relations, rights orientations, images and models of nursing, issues of language, conceptual frameworks and the differences between ethical problems and ethical dilemmas.

To fully participate in ethical discussion and decision making the individual must be able to make ethical judgements and this requires a sophisticated grasp of ethical concepts and knowledge. Inservice study days, workshops and seminars may only be of limited benefit in developing ethical judgement since "educational interventions shorter in duration than three weeks do not seem effective" (Rest, 1986, p. 177). Formal education has been identified as "the most significant factor in the fostering of moral judgment competence" (Lind, 1985, p. 100). For nurses, therefore, such knowledge may best be acquired as part of a formal nursing curriculum at the tertiary level of education.

### 3.1.7 Nursing Education in Australia

In Australia the recent nation-wide transfer of nursing education from hospital based programmes to institutions of higher learning has provided an opportunity for greater emphasis to be placed on preparing nurses to deal with the ethical domain (Lyneham, 1988).

For the first time in the state of Western Australia a university based nursing programme has included a unit of study devoted solely to ethical issues in nursing. This unit was commenced in February 1992 in a post registration degree programme for practising registered nurses.

### 3.2 Nursing Research and Ethics

#### 3.2.1 Introduction

Research exploring the ethical domain of nursing is a recent phenomenon. Armingier (1977) found only three citations for ethics in the first 25 years of publication in the prestigious journal Nursing Research (cited in Gortner, 1985). The last decade, however, has seen an increase in nursing ethics research, particularly in the area of nursing education.



### 3.2.2 Limitations of Research to Date

Studies concerning the ethical reasoning of nurses have used a wide variety of approaches related to topic of concern, sampling, and study design. There has been little in the way of replication, and findings have been inconclusive or inconsistent (Corley and Selig 1992; Silva and Sorrell, 1991; Ketefian 1989b). There is also confusion about theoretical (Kohlbergian) and methodological issues. Gillon (1992) writes of misinterpretations of Gilligan's (1977, 1982) critique of Kohlberg's theory, mentioned previously. In their critique of research which has used the DIT to measure nurses' ethical reasoning Duckett, et al., (1992) reported inaccuracies and misperceptions about the use of the instrument stating that "the literature about the moral reasoning of nurses has been muddled by errors arising from the confusion of (DIT) scores" (p. 329). This is important since the DIT is the instrument most widely used to measure ethical reasoning among nurses. A further problem in assessing research is the low publication rate of research findings. Ketefian (1989a) reported that of the 34 studies she reviewed 28 were dissertations, with only 3 of those 28 appearing in the published literature. These reported difficulties were confirmed by the search of the literature undertaken for this study.

### 3.2.3 Instruments Used

In the search of the literature two instruments were identified as having been used to measure the ethical reasoning of nurses; the DIT, discussed earlier, and Crisham's Nursing Dilemma Test (NDT). Although the DIT served as a prototype for the NDT for both scoring and structure Crisham (1981) used vignettes of ethical dilemmas she found to be of common occurrence in nursing practice as the basis for her instrument, rather than the hypothetical, general dilemmas of the DIT. The NDT is discussed at greater length in the chapter on methodology (see p. 43).

Another instrument used to investigate the effect of nursing ethics education was Ketefian's Judgements About Nursing Decisions (JAND). This instrument was designed by Ketefian (1981b) to measure perceptions of ethical behaviour rather than ethical reasoning. The JAND, in similar fashion to the NDT, is a self administered objective test in which subjects check given items to respond to vignettes of ethical dilemmas occurring in nursing practice.

### 3.2.4 Ethics Education and Ethical Reasoning

The results of research to date investigating the effects of ethics education on the ethical reasoning of nurses

are inconsistent. A number of unpublished studies have produced mixed findings. Corley and Selig (1992) cited two studies which reported that previous ethics education did not significantly affect ethical reasoning; Kellmer (1983), who found "no significant difference in moral reasoning between students who had taken an ethics course and those who had not" (p. 382) and Keller (1985), who found that "education and previous ethics education were not significant factors in level of moral reasoning" (p. 382). In contrast, Ketefian (1989a) reported one unpublished study (Bell, 1984) which found "higher moral reasoning scores following an ethics course" (Ketefian 1989a, p. 179) and Mustapha & Seybert, (1989), cited Krawczyk's unpublished study of 1982 which found that "students who had a required ethics course scored significantly higher on measures of moral reasoning than students who did not have a required ethics course" ( p. 107).

Two published studies which support the view that a specific ethics course will have a positive effect on the moral reasoning of nurses are by Gaul (1987) and Frisch (1987). Gaul's (1987) study was not concerned with ethical reasoning but rather with perceptions of likely ethical behaviour. This study used the JAND to measure differences in perceived ideal ethical behaviour (ethical choice) and perceived likely ethical behaviour (ethical action) between two groups of baccalaureate nursing students, one of which had undertaken an ethics course.

Seventeen students enrolled in an elective ethics course were matched for position in the curriculum with a control group of twenty volunteers from those not enrolled in the course. Ethical content was professed to be integrated throughout the curriculum of the university's school of nursing.

Those enrolled in the elective ethics course had higher total and mean scores for both measures, and consistently higher mean scores on individual vignettes, but  $t$  tests for independent samples revealed no significant difference between the two groups on either scale. However, exploring the relationship between ethical choice and ethical action between the two groups using Pearson's  $r$  revealed a significant positive correlation for the ethics group and a (non-significant) negative correlation for the control group. In a later discussion Gaul (1989) noted "the results [of other studies using the JAND] which indicate a lack of congruence between knowing the ethically correct action and actually choosing it, render the relationship demonstrated in the ethics students even more impressive" (p. 482).

While acknowledging the limitations of the small sample, Gaul (1987) concluded that a specific course in ethics within the curriculum may better allow students to relate ideal behaviour to realistic behaviour than a programme where ethics is professed to be integrated throughout the curriculum.

In the second study, the effects of a teaching strategy used to instruct students in nursing ethics was explored by Frisch (1987). This quasi-experimental design used Rest's Defining Issues Test (DIT) to pre and post - test a control group of 24 and an experimental group of 28 junior baccalaureate nursing students. The experimental group, which comprised three clinical strands, received six one hour biweekly sessions of instruction in nursing ethics using the value analysis method which "emphasises the need for careful evaluation and weighing of facts preparatory to drawing conclusions regarding ethical problems" (Frisch, 1987, p. 328).

A significant gain was observed in the experimental group in the D score, which ranks subjects in one of Kohlberg's six stages of moral development. No significant change was reported for either group in the P score, which is interpreted as the relative importance the subject gives to items representing principled thinking (that is, thinking in terms of Kohlberg's stages 5 and 6). The reliability of the D score has been questioned by Ketefian (1989a), although Duckett et al., (1992) report "test-retest correlations averaging in the .80s and Cronbach alphas in the .70 to .80 range" (p. 326) for both scores.

Although there was no significant change in the P score of either group, one of the clinical sub-groups (in the

experimental group) did show a significant change in the P score. A qualitative evaluation questionnaire revealed that all the subjects in this sub-group had concurrently encountered a nursing ethical dilemma in their clinical work. Each claimed to have experienced some degree of "emotional discomfort", and they had, as a group, consistently discussed their concerns out of class. This finding is consistent with the theoretically expected effect of cognitive dissonance on ethical reasoning, especially in the context of a supportive educational framework.

Certain conclusions of this study based on the inappropriate comparison of raw test scores with normative DIT scores were questioned by Duckett et al., (1992). However, the use of the scores to examine differences between control and experimental groups was considered appropriate.

#### 3.2.5 Ethical Reasoning and Practising Nurses

The ethical judgement of practising nurses has not been widely researched. Generally, the ethical judgement of practising nurses has been measured in studies exploring differences between levels of education. Results have been inconsistent here also.

In a 1981 study Crisham measured the ethical reasoning of 225 subjects using two instruments, the researcher designed NDT and Rest's DIT. The study compared five groups with different levels of education. Each instrument had a scale measuring the relative importance given to principled thinking items (NP and P scores respectively) and a scale for measuring the subjects' familiarity with the vignettes presented. The NDT had a scale measuring the relative importance given to practical considerations (PC score).

For both instruments the principled thinking scores correlated with level of education. There was an exception, however, with one group out of educational sequence in NDT scores. This was a group of sophomore students enrolled in the first week of a baccalaureate programme in nursing, designated the pre-nurse group. The mean NP score for this group was higher than that for either the graduate staff nurse group with Bachelor degrees or the graduate non-nurse group (graduate student teachers). Also the NP scores for both the pre-nurse and non-nurse groups were higher than the staff nurse groups (but lower than the expert nurse group). PC scores for more experienced nurses were significantly higher than scores for less experienced nurses. Crisham (1981) discussed the possible factors that may have contributed to these differences including the effects of the "hospital milieu", the various contextual pressures of the hospital setting, and historical factors associated

with the apprenticeship style of training and the control of institutions.

Similar observations were made by Ketefian (1981a, 1981b) in two studies with practising registered nurses. Ketefian (1981a) used the DIT in upholding the hypothesis that there is a difference in moral reasoning between professionally educated nurses and technically prepared nurses. The levels of moral reasoning of the professionally educated group of 43 (those with a baccalaureate or higher degree) were more advanced than the technically prepared group of 36 (those with a hospital diploma or associate degree) with the confidence limit set at .01. Questions concerning the exercise of ethical reasoning by practising nurses in the complex milieu of the clinical setting were raised in the discussion of findings. In a second study utilising the same sample of 79 practising registered nurses Ketefian (1981b) used the DIT to measure moral reasoning and a researcher designed instrument, the JAND, to measure perceptions of moral behaviour. Although not central to the study's purpose she noted that there was a difference between the two groups in the acquisition of knowledge and values of an ethical nature. Both researchers noted the need for further delineation of these factors.

In a more recent study of practising registered nurses Corley and Selig (1992) explored the moral reasoning of 75 volunteer critical care nurses at one 850 bed teaching



hospital in a study seeking to expand the research using the NDT. No correlations were found between measures on the NDT or with age and education. Years of critical care experience correlated negatively with Nursing Principled Thinking ( $r = -.30$ ,  $p < .01$ ). The researchers also reported a wide variation in ranking nursing principled thinking items (the NP score) for the different scenarios. Subjects had to rank six items for each dilemma two of which reflected nursing principled thinking. Across the six dilemmas the choice of an NP item as the most important consideration ranged from a reported high of 81% to a low of 27%. Choosing an NP item as the second most important consideration ranged from a reported high of 57% to a low of 9%. In the discussion section the researchers commented that their results continued the pattern of inconsistent findings.

### 3.2.6 Additional Variables

During the process of reviewing the literature seven variables (defined earlier, see p. 13) which may have influenced the ethical reasoning of the subjects of this study were identified. These were titled initial registration qualification, length of experience, previous exposure to education in ethics, completion of a unit of study in legal and ethical issues in nursing, age, the number of units of the study programme completed and principal area of experience.

Four of these variables were concerned with nurses' education (initial registration qualification, previous exposure to education in ethics, completion of a unit of study in legal and ethical issues in nursing and position in the programme). The remaining three have been identified in previous research; length of experience, age and principal area of experience. The seven variables were included in this study for the following reasons.

Initial Registration Qualification: The effects on ethical reasoning of formal education may be more pronounced in those nurses who gained their initial nursing education at a tertiary institution as opposed to those who were educated in the apprenticeship style in hospital based training programmes. As noted above formal education has been identified as the most significant factor in developing moral judgement (Lind, 1985) and research findings indicate that higher levels of education are associated with significantly higher measures of ethical reasoning (Crisham, 1981; Ketefian, 1981a, 1981b).

Previous exposure to education in ethics: Any previous exposure to ethics education may well have had significant effects. Such exposure may have been reflected in higher ethical reasoning scores clouding the effect of the unit in ethical studies under investigation.

Completion of a unit of study in legal and ethical issues: The study of ethics was previously combined with that on legal issues in nursing. It was assumed that a number of participants may have undertaken this unit either as part of the diploma course in nursing or as a previously compulsory unit in the course for registered nurses. This may have had a similar effect to previous exposure to ethics education.

Position in programme: The effects on ethical reasoning of formal education may have been more pronounced in those nurses who were very near completion of the degree course compared to those just starting the programme.

Length of experience: Years of experience as a registered nurse may have had an effect on the measurement of ethical reasoning as suggested by Crisham's (1981) study reported above.

Age: Theoretical considerations suggested ethical reasoning may increase with age (Rest, 1979, 1986).

Principal Area of experience: Nursing experience is usually expressed in terms of the medical speciality areas where nurses work, for example the Intensive Care Unit (ICU), a medical ward or a surgical ward. This is essentially an administrative classification. The aim of the classification in the present study was to explore differences in ethical reasoning based on nursing

experience with the client, each category intending to reflect a nurse-patient relationship developed over time. An assumption was that increased involvement with the patient may contribute to greater ethical dissonance and therefore lead to increased measures of ethical reasoning.

### 3.3 Summary

Although ethical decision making is generally accepted as integral to nursing practice, nurses are often perceived as being unprepared to deal with ethical problems. This unpreparedness is linked to previous nursing education. Formal education is a major factor in the development of ethical reasoning.

There has not been a great deal of research into the effects of ethics education on nurses, particularly practising Registered Nurses. The findings of studies to date have been inconsistent and trends have not emerged to guide higher level research. Methodological errors and theoretical misinterpretations have clouded findings and led to divergent and perhaps inappropriate conclusions (Duckett et al., 1992; Gillon, 1992). This study aimed to further explore the effects of ethics education on the ethical reasoning of practising nurses and to add to findings on the validity and reliability of Crisham's NDT as an instrument for measuring ethical reasoning among nurses.

## CHAPTER FOUR

### METHODOLOGY

This study explored the effect of a compulsory, semester length educational unit on the ethical reasoning of practising registered nurses. This unit was solely concerned with ethical issues in nursing and was conducted at a university school of nursing as part of degree programme for already registered and practising nurses.

#### 4.1 Subjects

Subjects for this study were drawn from students enrolled in a degree programme for practising registered nurses at a university school of nursing in Western Australia. The first group (Group 1) consisted of registered nurses who had completed the unit on ethical issues in nursing, and the second group (Group 2) consisted of registered nurses who had not undertaken the unit. One hundred subjects were selected from each group by random sample. The relatively large sample size reflected the expected response rate of approximately 50% based on reports of recent studies using questionnaires conducted in the school of nursing (personal communication from research consultant, April 1992). A reviewer of the proposal for this study made similar comments (July 1992).

Potential subjects for Group 1 were chosen from those who had completed the unit in the first academic semester of 1992. Of these, 3 were eliminated because they had re-enrolled in the unit (for unknown reasons) and a further 29 were eliminated because they were students in different programmes, mental health nursing, honours, and tertiary diplomas. It was assumed that these students did not belong to the same population as that being investigated.

Table 4.1

Selection of Potential Subjects

Group 1

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Completed unit	139
Total eliminated	32
Potential Subjects Group 1	107

Group 2

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Enrolled in programme	632
Total eliminated	168
Potential Subjects Group 2	464

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Potential subjects for Group 2 were chosen from students enrolled in the degree programme for registered nurses in the second academic semester 1992. Excluded were those who had either completed the unit in the first semester 1992 or were (then) currently enrolled to do the unit. A

further 3 were well known to the researcher and were excluded because of a possible breach of the anonymity and confidentiality requirements. The selection of potential subjects is summarised in Table 4.1.

For each group a list consisting of the names of potential subjects was arranged in alphabetical order. Two sets of computer generated random numbers were then used to select one hundred subjects from each group.

Of those contacted 65% replied, a higher than anticipated response rate. Just over 12% of replies were eliminated because of errors in completing the NDT, these involved either omissions of scores or a duplication of rankings. The selection of participants is summarised in Table 4.2.

Table 4.2  
Selection of Participants

	Group 1	Group 2	Total
Replies received	62	68	130
Eliminated	9	7	16
Valid documents	53	61	114

## 4.2 Design

A quasi-experimental posttest only design was used in which there were two groups of practising registered nurses one which had undertaken the unit in ethical issues in nursing and one which had not.

The dependent variables in this study were the NP and PC scales from the NDT. The independent variable was the study unit "Ethical Issues in Nursing" undertaken at a university school of nursing in the first semester of academic year 1992. The seven variables which may have influenced the ethical reasoning of the subjects of this study were initial registration qualification, length of experience, previous exposure to education in ethics, completion of a unit of study in legal and ethical issues in nursing, age, the number of units of the study programme completed and principal area of experience.

## 4.3 Instruments

Two instruments were used in this study: Crisham's (1981) NDT (see Appendix F) and a researcher-designed demographic data sheet (see Appendix E). The demographic data sheet asked seven questions which addressed the seven additional variables discussed in the literature review. The NDT is discussed hereunder.



#### 4.3.1 Reasons for Using the NDT

Three instruments used to measure ethical reasoning were identified in the literature search: the MJJ, the DIT and the NDT. The one chosen for this study was the NDT. It was chosen for three reasons.

Firstly it uses actual dilemmas found in nursing and was thus considered appropriate for investigating the ethical judgement of practising registered nurses. Crisham (1981) writes "exploring the relationship between subjects' moral judgement and responses to actual moral dilemmas is a beginning step in the process of relating moral judgement assessment to the ethical problems faced in particular life situations" (p. 104).

Secondly the NDT has the advantage of simplicity of scoring and modest cost. The MJJ requires intensive training of the interviewer for both administration of the test and subsequent scoring. The DIT can only provide one scale, the P scale, when manually scored. Computer scoring provided by the Center for the Study of Ethical Development at the University of Minnesota can give two additional scales. However this entails additional time, about 6 weeks, and expense, about \$US300, for a study of this size (correspondence from the Center for the Study of Ethical Development, University of Minnesota, March 1992).

The third reason for using the NDT was that it provides additional information for analysis, a scale giving the relative importance the subject gives to practical concerns when making ethical decisions. This may be useful when exploring the ethical judgement of practising nurses. These factors make it suitable for the present study.

#### 4.3.2 Reliability and Validity

There is little information readily available on the validity and reliability of the NDT. Only two published studies were identified in the literature search, Crisham (1981) and Corley and Selig (1992).

The DIT served as the prototype for the NDT with the NP and PC scores on the NDT indexed in a similar fashion to the P score on the DIT. Crisham (1981) reported a significant low positive correlation between the DIT P score and NDT NP score (no correlation coefficient was given). Cronbach's alpha for the PC score was .39 and for the NP score .57 (Crisham, 1981). Corley and Selig (1992) reported a Cronbach's alpha of .36 for the NP score. Further use of this instrument is required to contribute to its refinement, and further establish its validity and reliability.

#### 4.3.3 Using the NDT

The NDT contains six vignettes each focussing on an ethical issue and representing an area of clinical nursing:

Newborn with anomalies: Defining and promoting quality of life (maternity nursing).

Forcing medication: Determining the right to decide (mental health nursing).

Adult's request to die: Defining and promoting quality of life (critical care nursing).

New nurse orientation: Allocation of nursing resources (paediatrics nursing).

Medication error: Maintenance of professional and institutional standards (medical nursing).

Terminally ill adult: Deciding the right to know (surgical nursing).

Subjects are asked to complete three multiple choice sections for each dilemma. The first section, Willingness to Act, asks subjects to choose one of three options: (a) to take a proposed action, (b) can't decide or (c) not to take a proposed action. Crisham (1981) reported that the aim of this section was to direct the subject's attention to the conflict inherent in the dilemma.

The second section asks subjects to rank six items in order of importance. One item reflects practical

considerations and its ranking gives the PC score. Three items reflect Stage 2, Stage 3 and Stage 4 ethical reasoning (see Appendix A). The last two reflect principled thinking, that is, both Stage 5 and Stage 6 together and are summed to give the Nurse Principled Thinking (NP) score. Table 4.3 gives examples from the NDT reflecting thinking at the different stages. These stages are equivalent to Kohlberg's stages of ethical reasoning.

Table 4.3

Examples of Stages of Ethical Thinking  
from the NDT

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Stage 2. Could I check with a colleague and  
avoid the consequences of deciding?

Stage 3. Is the patient someone that I like and  
care about?

Stage 4. What guidelines are specified in the  
Unit Manual?

Stages 5 and 6 (Principled Thinking). Does the  
patient have the right to decide about the  
use of heroic measures?

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The third section, Familiarity, is a five point scale measuring familiarity with the dilemma (F score) with choices ranging from "1 = made a decision in a similar dilemma" to "5 = difficult to take the dilemma seriously

as it seems unreal". Familiarity is defined as "the subject's degree of involvement with similar dilemmas" [to those given in the instrument] (Crisham, 1981, p. 108).

The NP scale was used as the dependent variable to investigate the principal research question. The PC scale was used to investigate the difference between the two groups in the consideration given to contextual issues. The F scale was used to assess subjects' familiarity with the scenarios depicted.

The stage scores were not used to measure differences between the two groups. In studies which have used either the NDT or Rest's DIT it is the scale reflecting principled thinking (NP and P respectively), which has been most frequently cited. Crisham (1981) reported significant differences between the groups studied for Stage 2 and Stage 4 scores but not Stage 3 scores. She found no consistent pattern across the groups for Stage 3 and Stage 4 scores but found Stage 2 scores were inversely related to level of education. Corley and Selig (1992) did not report on stage scores. Given the limited reported findings on stage scores and the subsequent difficulty in analysis their use was considered beyond the scope of this study. However they were used to assess internal consistency reliability. A description of the design of the instrument can be found in Crisham (1981).

A copy of the letter from Dr Crisham authorising its use can be found in the Appendix E.

#### 4.4 Procedure

The study was undertaken during the second semester of academic year 1992. The Department of Student Services of the university was formally requested to assist in the study by providing names and addresses of students. Selection of subjects was undertaken by the researcher, under academic supervision.

A package containing the NDT, the demographic data questionnaire, a reply paid envelope and the covering letter was then mailed to each subject. Each set of documents was allocated a unique number. This made it possible to send reminder letters to those who had not responded and allowed sorting into groups. A follow-up letter was sent to non-respondents two months after the initial mailout. The initial research plan was to send reminder letters after one month but a family bereavement caused the researcher to delay mailing by one month.

The questionnaires were collated, scored and the results entered on disc for computer analysis by the researcher.

#### 4.5 Limitations

A pretest-posttest design may have better defined the effects of the educational unit on ethical judgement but the time frame needed to conduct such a study was considered beyond the scope of an Honours degree.

This study did not seek to measure ethical behaviour, but rather the reasoning process that informs any decision about action.

This study did not seek to measure the effectiveness of a particular educational technique. It explored the effect an educationally formal course of study in ethics may have had on the ethical judgement of practicing registered nurses.

It was not possible to assign subjects randomly to the two groups. There were, however, no significant differences between Group 1 and Group 2 for any variable other than the NP scale.

#### 4.6 Ethical Considerations

The School of Nursing gave Ethical approval for the conduct of the study. During the study only the researcher knew the identity of participating subjects. With the exception of those participants who requested a copy of the results of the study all records identifying

participants and members of the target population have been destroyed. Those participants who requested a copy of the results (22 in all) will be sent a precis of this thesis (which will also be used as the basis of an article to be submitted to an appropriate nursing journal). Without exception all records identifying individual responses to the questionnaire and instrument have been destroyed. The results of this study were not used in any form of assessment or in any other way used to discriminate for or against any subject during the course of the research. With the destruction of all identifiers of any subject's results such misuse is now impossible.



## CHAPTER FIVE

### RESULTS

The statistical procedures used on the raw data were performed using the programme SPSS for WINDOWS Release 5.0.1.

#### 5.1 The Research Questions

A significance level of .05 was set for the investigation of the two research questions.

##### 5.1.1 The Principal Research Question

The principal research question asked if there was a difference in ethical reasoning between practising registered nurses who had completed the unit dedicated to ethical issues in nursing and registered nurses who had not undertaken the unit.

A  $t$  test for independent samples was used to explore differences between the two groups in the dependent variable, Nursing Principled Thinking (NP). Group 1, which had undertaken the unit dedicated to the study of ethical issues in nursing, had a significantly higher mean score ( $M=53.79$ ) than did Group 2 ( $M=51.54$ ,  $t(111)=2.37$ ,  $p<.05$ ).

No significant differences were found between the two groups in the variables length of experience, age and position in the programme using  $t$  tests for independent samples.

#### 5.1.2 The Subsidiary Research Question

The subsidiary research question asked if there was a relationship between the ethical reasoning of practising registered nurses and any of the variables; initial registration qualification, length of experience, previous exposure to education in ethics, completion of a unit of study in legal and ethical issues in nursing, age, position in the programme, principal area of experience.

Pearson's correlation coefficients were used to explore the relationship between the NP scale and length of experience, age, and position in programme. A  $t$  test for independent samples was used to identify any significant difference between those who had done the legal and ethical issues unit and those who had not. Three of the variables (initial registration qualification, previous exposure to education in ethics and area of major experience) were omitted from further analysis for reasons discussed below.

Table 5.1 shows that no significant correlation was found between NP scores and the variables length of experience, age or position in the programme.

Table 5.1

Correlation Between Selected Variables and NDT Scores

	F	NP	PC
Experience	r= -.11	r= -.01	r= -.05
Age	r= -.03	r= .04	r= -.07
Units Done	r= -.10	r= .03	r= -.01

Sixty four subjects indicated that they had undertaken the unit Studies in Legal and Ethical Issues in Nursing or a similar unit at another university school of nursing. The  $t$  test for independent samples revealed no significant difference in NP scores between those who had undertaken the legal and ethical issues unit(s) ( $N=64$ ,  $M=52.97$ ) and those who had not ( $N=49$ ,  $M=52.06$ ,  $t(97)=.89$ ,  $p>.05$  (one subject failed to complete the question)).

All participants indicated that they had first become registered nurses after gaining an Hospital Based Diploma

(HBD) in nursing. As the subjects constituted only one group for this variable no further analysis was possible.

All participants in Group 1 had completed an accredited and certified course exclusively devoted to ethical issues, having completed the unit "Ethical Issues in Nursing". Four of these subjects indicated previous exposure to a non-accredited course. All but five of the participants in Group 2 indicated no previous exposure to education in ethics. The five exceptions indicated exposure at the non-accredited level. Given the small numbers in the sub-groups no further analysis was performed.

It was not possible to place each subject into only one principal area of experience because of the wide mix of experience. Also in many cases the sum of years for each area of experience did not equal the number of years of experience. The range of "missing" years was from 1 to 12. The data were considered flawed and unable to support any valid inference and were, therefore, omitted from further analysis.

### 5.2 Other Dependent Variables from the NDT

There was no significant difference in mean scores for the PC scale between the group which had undertaken the unit ( $M=19.72$ ) and the group which had not ( $M=19.77$ ,  $t(111)=-.09$ ,  $p>.05$ ).

There was no significant difference in the mean scores for the F scale between the group which had undertaken the unit ( $M=12.89$ ) and the group which had not ( $M=13.49$ ,  $t(112)=-1.16$ ,  $p>.05$ ). The mean score of both groups fell within the range 6-17, defined by Crisham (1981) as indicating familiarity with the dilemmas. Overall, 105 subjects (92%) indicated familiarity with the dilemmas. Only 9 subjects had total F scores greater than 18, that is, indicating unfamiliarity with the dilemmas. Although the maximum score possible for this scale was 30, the maximum score obtained by any subject in the present study was 20.

Table 5.2

Comparison of NDT Mean Scores

	NP	PC	F
Corley & Selig 1992	50.9	18.2	11.5
Crisham 1981 <sup>*</sup>	55.3		
Present Study			
Group 1	53.79	19.72	12.89
Group 2	51.54	19.77	13.49

<sup>\*</sup> Reported in Corley & Selig, 1992

Table 5.2 shows the mean scores obtained for the NP, PC and F scales in this study as well as those reported in the literature to date. These are discussed in Chapter 6.

### 5.3 Internal Reliability Assessment

Internal reliability was assessed using Cronbach's Alpha for the NP, PC and Stage 2, Stage 3 and Stage 4 scores. Table 5.2 shows these coefficients as well as those coefficients reported by Crisham (1981), and Corley and Selig (1992). These findings are discussed in Chapter 6.

Table 5.3

Internal Consistency Reliability

(Cronbach's Alpha)

	Present Study	Crisham (1981)	Corley & Selig (1992)
Stage 2	.45	.45	
Stage 3	.08	.26	
Stage 4	.52	.50	
NP	.49	.57	.36
PC	.17	.39	

## DISCUSSION

### 6.1 Ethics Education and Ethical Reasoning

#### 6.1.1 The Principal Research Question

The findings of this study indicate that an ethics course did have a significant positive effect on the ethical reasoning of nurses when undertaken in the context of formal university education. There was a significant difference between the means of the principled thinking scores (NP) of the group of nurses which had undertaken the unit in ethical issues in nursing and the group which had not. This finding answers the principal research question in the affirmative and is in keeping with the cognitive theory of moral development described by Kohlberg.

However this result needs to be treated cautiously because of the low internal consistency scores (discussed later) and because of the possible effects of extraneous variables. It is possible that the significant difference in mean scores was due to, or compounded by, other variables. The method of instruction may have contributed significantly to the increased measures of ethical reasoning found in this study. The lecturer who designed and conducted the unit reported that an interactive approach, utilising group discussions and case studies, was used to challenge existing beliefs. This approach

may well have induced a state of cognitive dissonance in students and thus brought about higher levels of ethical reasoning. Similar teaching methods have been reported as increasing levels of ethical reasoning (Rest, 1986) whereas "discipline-oriented, information-laden courses on traditional academic topics seem not to be so effective" (ibid, p. 177). The inconsistent results of previous studies reported in the literature review may be due, in part, to similar factors. Gaul (1987), for example, did not report the teaching approach used in her study.

Further research is indicated to better determine the effects of ethics education. Silva and Sorrell (1991) and Ketefian (1989a) suggested that future studies may best be undertaken by research teams lead by established nursing researchers and that experimental designs be used whenever possible. The use of teams is more likely to "build programmatic research that is designed to approach knowledge accrual systematically and over time [and] make it feasible to design complex studies" (Ketefian, 1989, p. 189-190).

Experimental designs to assess the efficacy of particular programmes or approaches to the teaching of ethics may be appropriate. Such ongoing curriculum evaluation studies should better be able to control for variables such as the method of instruction, and contribute to a greater understanding of the factors affecting ethical reasoning.



### 6.1.2 The Subsidiary Research Question

Seven additional variables were examined in this study. Four of these variables were concerned with differences in education (initial registration qualification, previous exposure to education in ethics, completion of a unit of study in legal and ethical issues in nursing and position in the programme), two with time as a factor (length of nursing experience and age) and one with the context of experience (principal area of experience).

Two variables were not analysed. All subjects reported the same initial registration qualification thus making further analysis impossible and the number of subjects who had previous exposure to ethics education in either group was small and further analysis was considered unlikely to yield any valid result. There were no significant findings for the remaining five variables.

The apparent lack of effect of previous studies in legal and ethical issues in nursing studies may be the result of combining two subject areas which, at their highest levels, require different modes of thinking. Legalistic thinking is a characteristic of the conventional level of ethical reasoning in Kohlberg's hierarchy and is perhaps likely to predominate in a mixed unit such as this. Furthermore, in the context of an undergraduate degree for some other professional qualification, a unit of study in legal issues will be concerned not with the law

in the abstract or of itself, but with legal consequences as these affect the practitioner. Thinking at this level, the concrete effects on the self, is more characteristic of pre-conventional Kohlbergian ethical reasoning. Also, anecdotal evidence from a lecturer who has conducted the unit as well as from students who have completed the unit suggested that much greater emphasis was given to legal issues in past presentations.

A positive correlation between NP scores and the number of units of the programme completed is in keeping with Kohlberg's theory. However, advances in cognitive abilities engendered by formal education, while necessary, are not sufficient for advances in ethical reasoning. As discussed under the conceptual framework it is the resolution of ethical dilemmas which leads to advances to higher stages of ethical reasoning. The results of nursing research into level of education and ethical reasoning are inconsistent with reports of positive, negative and nonsignificant relationships (Ketefian, 1989a). These inconsistent findings may well be related to methodological problems of nursing research such as the confusion of P, P%, and D scores in the DIT discussed by Duckett et al., (1992).

There were no significant findings for age in the present study. Ketefian (1989b) noted that reported results for age were inconsistent. Crisham (1981) reported no significant findings for age but suggested years of

experience as a registered nurse may have a negative effect on ethical reasoning. Corley and Selig (1992) reported no significant findings for age but found a negative correlation between principled thinking and years of critical care experience ( $r = -.30$ ,  $p < .01$ ). Rest (1979, 1986) found moral reasoning progresses developmentally with time. Psychological changes over time are necessarily complex reflecting the progressive interplay of multiple factors. For instance developmental changes within the individual (in cognition and personality for example), the increasing quantity and different qualities of experienced phenomena, the individual's responses to these phenomena are all constantly interacting. Further delineation and investigation of factors such as these is indicated.

Although the variable for principal area of experience was not used in any analysis some observations arising from the consideration of this variable are discussed here.

The classification of nursing experience based on medical speciality appears to be inappropriate when investigating ethical reasoning. As discussed previously, this is essentially an administrative classification based, in part, on patient acuity levels. Research into occupational stress among nurses has often focussed on critical care (high patient acuity) nursing as this, presumably, has been perceived as more stressful. While

ethical distress has been identified as an important component of stress among critical care nurses, as cited earlier, such ethical distress may be as great in many other areas of nursing. The ethical tensions surrounding such issues as living wills, the presence or absence of not for resuscitation orders, heroic measures to preserve life, quality of life debates, and effects on relatives of profoundly incapacitated persons may be found in a number of nursing situations.

In the present study the question concerning area of experience was not well designed. This is a more complex variable than was at first realised. The nature and quality of human relationships are affected by variables such as time and the emotional intensity of different life events. These variables may have differing effects in different nursing contexts. Defining nursing experience in terms of nurse-client relationships may be a more valid approach for future research.

## 6.2 The Nursing Dilemma Test

Assessment of the NDT remains problematic. As reported in the literature review there have been only two studies published (Corley and Selig, 1992; Crisham, 1981). The internal reliability coefficients for NDT scales remain low and inconsistent (see Table 5.3).

Crisham (1981) did not report any raw scores, mean scores or standard deviations for any of the NDT scales. Corley and Selig (1992) provided mean scores which were lower than those obtained in the present study (see Table 5.2).

Although Corley and Selig (1992) discussed each scale individually the reason guiding the selection of some of the data presented is not clear. As an example, for the Willingness to Act scale Corley and Selig (1992) gave the percentages of those nurses who chose the option to act in the way proposed by the instrument for each dilemma. Crisham (1981) used this scale to direct the subject's attention to the conflicting issues in the dilemma. However she did not provide any guide as to the ethical issues involved in taking or not taking the actions proposed (if indeed any was intended). The use of this scale for any sort of analysis would appear to be inappropriate. Similarly, Corley and Selig (1992) identified the choice of most important and second most important items for the NP and PC scales for some of the dilemmas, reporting these as percentages. Although these indicated a wide variation in responses (a finding also of the present study) their selection for discussion is unclear.

Corley and Selig (1992) suggested adding more contextual information to the vignettes of the NDT to improve its reliability. Nurses in their study (and in other cited research) sought more contextual information through

comments written on the instrument. Corley and Selig (1992) see the use of actual dilemmas which occur in nursing as a great strength of the NDT, and cite its basis in cognitive theory and its justice orientation as a major limitation.

Such may not be the case. As noted above, Kohlberg specifically sought a cognitive, rational approach to morality to distinguish objective reasons from subjective decisions. Because it involves particulars the context may have significant meaning for a subject, a meaning relevant to behaviour, whether that behaviour be actual or imagined, in the future or the past. If this is the case then greater and more meaningful contextual information may confound measurement of ethical reasoning as described by Kohlberg. In this study changes in the NP scale were not reflected by changes in the PC scale and Crisham (1981) reported that experienced nurses had significantly higher PC scores but not significantly higher principled thinking scores. A hypothetical scenario may be better in evaluating the "purely" cognitive processes of Kohlbergian ethical reasoning.

Contextual factors may better be explored by research into ethical behaviour or decision making. Such research may be necessary before the issues of context, attachment and the subject's perspective (which were raised by Gilligan, 1977, 1982) can be integrated with Kohlberg's conceptual framework. As suggested by Cassidy (1991) both

qualitative and quantitative designs may be appropriate. Until the role of contextual factors in ethical reasoning is more clearly defined, an instrument using hypothetical scenarios, such as the DIT, may better delineate levels of ethical reasoning as well as allow (perhaps) more valid comparisons with different populations.

### 6.3 Summary

The present study concludes that a unit of study in ethics education has a significant positive effect on the ethical reasoning of practising nurses. However, results need to be treated cautiously in the light of the low reliability scores for the NDT.

Reviewers of previous nursing research into the ethical reasoning of nurses have described methodological inadequacies and theoretical misinterpretations and have questioned the conclusions of some studies (Duckett et al., 1992; Gillon, 1992; Silva and Sorrell, 1991 & Ketefian, 1989a, 1989b). The present study also found difficulties in analysing results stemming from the low publication rate of research findings, wide variety of study designs and study purposes, and conflicting interpretations of theory.

The inconclusive findings of research in the ethics education of nurses may be clarified by a more systematic approach to the study of the effects of ethics education

on nurses' ethical reasoning through the use of nursing research teams led by established researchers using experimental study designs.

Further research together with the continuing theoretical debate is needed to better define the complex issues involved in ethical reasoning, decision making and behaviour.



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## APPENDIX A

### Kohlberg's Stages of Moral Development

Hereunder is a brief description of the six stages (within three levels) of moral development postulated by Kohlberg. This description has been derived from Kohlberg, et al. (1983) and Duska and Whelan (1977).

#### LEVEL I The Preconventional Level

At this level the person (usually considered a pre-adolescent) responds to external rules and cues of right or wrong, good or bad, and interprets these in terms of tangible consequences to the self, reward or punishment, pleasure or pain.

##### Stage 1 The Punishment and Obedience Orientation.

Consequences of an action determine its rightness or wrongness without regard to any other meaning or value. Examples of this may be found in fairy tales of "the boy who cried wolf" variety.

##### Stage 2 The Instrumental Relativist Orientation.

Right action is in the provision of personal (and sometimes others') satisfaction. A marketplace view of interpersonal relations prevails. Fairness and equality are interpreted pragmatically - for example pleasant or unpleasant consequences for the self. An example of this stage is "I'll get a chocolate if I tidy up my room now".

## LEVEL II The Conventional level

Correct action is based on expectations of family and group. This is not just a matter of conformity to expectations but of loyalty, active support and identity with the group.

### Stage 3 The Interpersonal Concordance or "Good Boy-Nice Girl" Orientation.

Good is pleasing and receiving approval from others of the group. Self sacrifice for and identity with the group are valued, although idealised behaviour remains naive and stereotyped. The notion of pleasure moves from the purely physical onto the psychological plane.

"Miss goody two shoes" is an example of Stage III, a parent's favourite who never makes a fuss.

### Stage 4 The Law and Order Orientation.

This stage emerges, as with previous stage progressions, from inconsistencies and conflicts in the preceding stage. Difficulties of identity and loyalty between groups impels the person to discover the rules governing the greater social order, those which address everyone's rights. Doing one's duty and maintaining the social order (through respect for its moral premise) become the primary values. Such individuals may appear cold and even callous in their absolute respect for legal authority and the application of "The Law". Higher court appeal decisions reflect this stage where decisions are based on the law not the contextual factors of each case. This may

"very well be the stage of the majority of adults ... reverence for the law and legitimate authority ... is seen as the ultimate guarantee of peace, order and the individual's rights" (Duska & Whelan, 1977, p. 65).

### LEVEL III The Postconventional Level

The defining criterion for this level, also known as the autonomous or principled level, is autonomy in judgement. Here the person chooses and owns his or her moral decisions arrived at through principles of reason and no longer determined by fear (Stage I), pleasure (Stage II), the group (Stage III), or lawful authority (Stage IV).

#### Stage 5 The Social Contract - Legalistic Orientation.

Social utility (the common good), democratic and rational decision-making, and review and reform, bound together in a legal framework are the hallmarks of this stage.

However, the law is to serve people and should be critically and rationally appraised to see if it fulfills this service. An individual at this stage will assess the law first to see if it fits the particular circumstance.

The parable of the good Samaritan is an example. Those passing the injured man did so because to help would have meant breaking holy law. The good Samaritan, no less righteous, broke that law and thus served the higher interest the law was supposed to serve.

Stage 6 The Universal Ethical Principle Orientation.

Kohlberg relies on literary and historical examples citing, for example, Martin Luther King and Ghandi. Such figures choose ethical principles "appealing to logical comprehensiveness, universality and consistency" which are abstract rather than concrete and "at heart, these are universal principles of justice, of the reciprocity and equality of human rights, and of the respect for the dignity of human beings as individual persons" (Kohlberg, cited in Duska & Whelan, 1977, p. 76). An example of this stage of ethical reasoning is Martin Luther King when he appealed to the higher value of human dignity when challenging the oppression of a minority group within his society, even though that oppression was legally sanctioned by the majority of that society.

**APPENDIX B**

**Copy of Initial Contact Letter**

Honours Programme Edith Cowan University  
Research Study in Ethics

Researcher: Ted Ambrose

Dear Student,

I am a student in the post registration nursing degree course undertaking a research study in ethics as a part of the Honours programme at Edith Cowan University.

You are one of a number of students I am asking to participate in this study. Your name has been chosen at random from a list of post registration nursing students enrolled at Cowan University.

I am asking you to complete the enclosed questionnaire which has been devised by an American nurse, Patricia Crisham, to learn about nurses' responses to moral (or ethical) dilemmas commonly found in nursing.

Participation in this study is entirely voluntary and your anonymity is guaranteed. Any identifying numbers on the enclosed papers are only to allow for follow up letters to be sent. Once sufficient replies are collected all records identifying participants shall be destroyed.

The results will NOT in any way, manner or form be used in assessing any part of your study programme or in any other form of assessment at any time.

Please read the instruction sheet, complete the enclosed questionnaire and return it in the enclosed return postage paid envelope.

Your participation is very much appreciated.

If you have any questions about the questionnaire, or any aspect of the study, please feel free to contact me at the above address or phone number. If you wish to know of the outcome of the study please let me know and I will be happy to send you a copy of the published results.

Your sincerely,

Ted Ambrose.

enc: Demographic information sheet (2 pages)  
Instruction sheet  
6 nursing dilemmas and questions

## APPENDIX C

### Copy of Reminder Letter



## Research Study in Ethics

Researcher: Ted Ambrose



Dear Student,

I wrote to you in September asking you to complete a questionnaire about nurses' responses to moral (or ethical) dilemmas in nursing. As I still need further questionnaires to complete my research I am writing to ask if you would complete and return the questionnaire.

I wish to emphasise that participation in this study is entirely voluntary and that your anonymity is guaranteed. The results will NOT in any way, manner or form be used in assessing any part of your study programme or in any other form of assessment at any time.

Please read the instruction sheet, complete the enclosed questionnaire and return it in the return postage paid envelope provided.

Your participation is very much appreciated.

If you have any questions about the questionnaire, or any aspect of the study, please feel free to contact me at the above address or phone number. If you wish to know of the outcome of the study please let me know and I will be happy to send you a copy of the published results.

Your sincerely,

Ted Ambrose.

APPENDIX D

Copy of Demographic Data Sheet

Demographic Data Sheet

1. What was your first registered nursing qualification?  
(Please tick as appropriate)

A. Hospital Based Diploma

B. University Diploma

C. Other (Please specify).....

2. Length of experience.

How many years have you worked as an RN at one half  
full time hours or greater (ie 20 hours per week or  
more?)

.....

3. Previous exposure to education in ethics.

Have you attended any session or series of sessions of  
greater than one days duration exclusively devoted to  
the study of ethics or ethical and moral issues?  
(Please circle or specify as appropriate)

A. No such previous exposure

B. Attendance at non accredited course  
(eg inservice study day, seminar, conference).  
Please specify

.....

C. Completion of an accredited or certified course  
(eg a unit at university)  
Please specify

.....

4. Have you completed the legal and ethical issues unit  
(NBS 3511) as part of the post registration degree  
programme at Cowan University?  
(Please circle)

Yes

No

5. Age.

What is your age in years at your last birthday?

.....

6. How many units of the post-registration degree course have you completed (1-13)?

7. Main area of experience.

In which one of the following areas have you predominantly worked and for how long?  
(Please write number of years next to appropriate category)

General Medical .....  
Haematology and Oncology .....  
Palliative Care .....  
Gerontology .....  
Community .....  
Psychiatry .....  
Surgical (includes all  
surgical areas and specialities) ..  
Midwifery .....  
Emergency .....  
Intensive Care .....  
Coronary Care .....  
Operating Theatre .....  
Administration .....  
Staff Development and Education ...  
Infection Control .....  
  
Other (please specify) .....

APPENDIX E

Copy of Letter from Patricia Crisham

2

10

10



## APPENDIX F

### The Nursing Dilemma Test



Name \_\_\_\_\_

Date \_\_\_\_\_

### Nursing Dilemmas

The purpose of this inquiry is to learn about how nurses think in responding to nursing dilemmas. There are no "right" or "wrong" answers to these dilemmas. Your thoughts about the information presented in the dilemmas are the important data.

Please respond to the six nursing dilemmas which have been obtained from the experience of staff nurses. There are three sections following each dilemma: Section A asks you to check what you would do in the situation; Section B asks you to rank six statements about relevant issues from the most important to the least important; Section C asks you to rate the extent of your previous involvement with similar dilemmas.

Anonymity will be assured. All data will be coded to remove possibility of identification or any connection with individuals.

Please respond to the dilemmas according to your own opinion. The important data are your thoughts in response to the nursing dilemmas.

The obstetrician in the Delivery Room handed a newborn with many overt anomalies to the nurse and said, "Don't do any extraordinary resuscitation." The nurse began to resuscitate the newborn and observed the deformities; the infant's bladder, part of the intestines and abdominal contents were not covered by muscle and skin. The sex of the infant was not evident. The infant's color and movement seemed normal indicating potential for life. The nurse wondered whether or not to resuscitate as vigorously as would be done with other newborns.

A. What should the nurse do? Check one response.

Should vigorously resuscitate the newborn \_\_\_\_\_

Can't decide \_\_\_\_\_

Should not vigorously resuscitate the newborn \_\_\_\_\_

B. The nurse considers the following six issues:

1. Will I be liable to legal action if I let this newborn die?
2. What specialized neonatal consultation is available?
3. Who has the right to decide whether this newborn should live or die?
4. Is it my responsibility to follow the physician's order?
5. What would be the effect of the birth of this child on the parents?
6. Should all newborns have the same basic claim on life?

From the list of considerations above, select the one that is the most important. Put the number of the most important consideration 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

## Forcing Medication

2

A 28 year old suspicious woman was committed to the Psychiatric Unit. She continually refused all medication because, as she stated, "It makes me feel strange." The psychiatrist ordered an intramuscular form of a tranquilizer to be administered if the patient refused the oral medication. The staff nurse was told by the Head Nurse to give the intramuscular medication while four staff members held the patient.

A. What should the nurse do? Check one response.

Should forcefully give the medication \_\_\_\_\_

Can't decide \_\_\_\_\_

Should not forcefully give the medication \_\_\_\_\_

B. The nurse considers the following six issues:

1. What do the other staff nurses on this Unit probably expect me to do?
2. What will make it easier for me to provide nursing care?
3. Will I be denying this woman her basic rights if I forcefully give the medication?
4. How much struggle and noise will occur on the Unit?
5. Do the current Commitment Regulations permit me to give medication with force to a committed patient?
6. Was this woman committed according to procedures that were socially equitable?

From the list of considerations above, select the one that is the most important. Put the number of the most important consideration 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

A 38 year old woman seemed to be aware of the seriousness of her symptoms as she prepared to go to surgery for an exploratory craniotomy. She stated that no heroic measures were to be done to prolong her life. A tumor so widespread as to be inoperable was discovered. She returned to the Intensive Care Unit in a coma. During that evening her respirations stopped. The nurse quickly grabbed the oxygen equipment but paused to consider whether or not to provide assistance with respirations.

A. What should the nurse do? Check one response.

Should provide assistance with respirations \_\_\_\_\_

Can't decide \_\_\_\_\_

Should not provide assistance with respirations \_\_\_\_\_

B. The nurse considers the following six issues:

1. Could I check with a colleague and avoid the consequences of deciding?
2. What guidelines are specified in the Unit Manual?
3. Do I have the right to make a decision about an individual's life and death?
4. Is the Hospital Resuscitation Team available for consultation?
5. Is the patient someone that I like and care about?
6. Does the patient have the right to decide about the use of heroic measures?

From the list of considerations above, select the one that is the most important. Put the number of the most important consideration 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

New Nurse Orientation

4

A staff nurse was given the responsibility of orientating a new nurse to the Pediatric Unit during the evening shift. Two nurses called in sick, so the nurse responsible for the orientation and the new nurse were solely responsible for the care of several infants including a newly admitted infant. The staff nurse knew that this one shift was allocated for the new nurse's orientation to the evening shift. The staff nurse also knew that if time was spent with the new nurse, the infants would not receive adequate care.

A. What should the nurse do? Check one response.

Should allocate time for orientation of the nurse \_\_\_\_\_

Can't decide \_\_\_\_\_

Should not allocate time for orientation of the nurse \_\_\_\_\_

B. The nurse considers the following six issues:

1. What is my professional obligation as specified in the staff nurse job description?
2. Do I owe it to this nurse to provide guidance for her?
3. Are there other sources of orientation information available to the new nurse?
4. How can I avoid being exploited in this situation?
5. Which is greater, the right to nursing care or the right to professional orientation?
6. Which alternative would provide the greatest long range benefit to patients?

From the list of considerations above, select the one that is the most important. Put the number of the most important consideration 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



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