CHARACTER AND ETHICAL BEHAVIOR OF NURSES

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The undersigned, appointed by the Dean of the Graduate School, have examined the dissertation entitled

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> [Daddy] said: All children must look after their own upbringing." Parents can only give good advice or put them on the right paths, but the final forming of a person's character lies in their own hands.
>
> *Anne Frank: The Diary of a Young Girl [1952]. July 15, 1944.*

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ABSTRACT

The purpose of this study was to examine relationships among personal normative characteristics, personal descriptive characteristics, and ethical behavior of nurses in practice. Little is known about the place of virtue theory in nursing practice and the factors that influence the nurse as moral agent.

One hundred thirty one registered nurses with at least six months' experience working in direct care positions in one of three hospital practice settings—urban, suburban, and rural—participated in the study. Three instruments were used with the randomized sample: (a) Demographic Data Form, (b) The INSURE Survey™, an instrument used to measure attitudes of potential employees, and (c) the Ethical Behavior Test (EBT), an instrument to measure nurses ethical reasoning and ethical action based on dilemmas reflective of clinical experiences. The research design was descriptive, correlational, and multivariate. The personal descriptive characteristic variables were (a) age, (b) years in nursing practice, (c) educational preparation, and (d) practice setting. The personal normative characteristic variables were the moral attitudes of (a) integrity, (b) reliability, and (c) work ethic. The ethical behavior variable was a measure of nurses' ethical reasoning.

The findings showed that two variables, associate degree in nursing educational preparation, and years in nursing practice, predicted higher integrity scores. None of the other variables—age, diploma or BSN/MSN educational preparation, or practice

setting—predicted moral attitudes of integrity, reliability, or work ethic. On average, nurses' integrity, reliability, and work ethic scores indicated they possessed attitudes desired and rewarded in the workplace.

Results of the study suggest that empirical assessment of character is complicated. Nurses' moral attitude scores are consistent with the public trust accorded them. Recommendations for further study are made, including refinement of the EBT, and the need to involve direct-care nurses in all phases of virtue ethics research.

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CHAPTER 1

Introduction

Increasingly, nursing is understood as a moral endeavor (Bishop & Scudder, 1996; Gastmans, Dierckx de Casterle, & Schotsmans, 1998). More than 3000 entries on nursing and ethics in the Cumulative Index of Nursing and Allied Health Literature online database 1982-1999 attest to the amount of interest in the moral dimension of nursing practice.

Most nursing ethics literature is discursive in nature. While important in the larger conversation, the corresponding lack of nursing ethics research raises concerns for nurses seeking guidance in clinical practice. Nurses act as moral agents by attempting to *do the good* with patients in their care (Bishop & Scudder, 1996). However, little is known from a research perspective about factors that influence the nurse as moral agent.

Problem Area

A recent trend in healthcare ethics may lead to new understanding regarding the moral nature of nursing practice. After decades of dominance by the bioethics principles of autonomy, beneficence, justice, and nonmaleficience, scholars are now calling for development of more comprehensive moral philosophies in healthcare. Virtue theory, relational theory, religious, and political theory are a few of the perspectives receiving renewed attention (Gillon, 1990). Of all the perspectives, virtue theory most clearly acknowledges the personal normative characteristics, or character, of the person. Bishop and Scudder (1996) argue that "separating the personal side of nursing from the impersonal--technological and professional—is unsound and detrimental to nursing

practice" (p. 20). Virtue ethics may be helpful in understanding the both normative and descriptive personal dimensions of the nurse as moral agent. Yet, the place of virtue theory in nursing practice and research is largely unexplored.

Background and Significance

Virtue theory is the study of the "state of character" (Nicomachean Ethics II: 5; Ross translation), produced by habits that bring about self-actualization so that one can flourish as a human being (Beabout & Wennemann, 1994). Virtue theory focuses on the agent, on his or her intentions, dispositions and motives. Virtues reflect character and a standard of moral excellence. According to Aristotle, "Human good turns out to be activity of soul exhibiting excellence . . . in accordance with the best and most complete . . . life" (NicomacheanEthics 1:7). The moral standard, then, becomes the good person (Pellegrino, 1995) who becomes so by having lived a good life.

Evidence of that this standard exists in day-to-day practice appeared in Robertson's (1996) ethnographic study of British doctors and nurses. Robertson found that while a common commitment to liberal and utilitarian principles existed among both doctors and nurses, nurses placed much greater weight on virtue and relational (feminist) theories when actually applying the same liberal and utilitarian principles. Nurses voiced virtue and relationship events far more often (16 events) than doctors (three events). One nurse reported that the "qualities needed to become a good nurse [as opposed to a good doctor] have more to do with character and morality . . ." (p. 294). Robertson concluded that all aspects of healthcare, even the most uncontroversial, were morally charged.

Several nursing authors also report findings that point to the place of virtue theory in nursing practice. Smith and Godfrey (1999) found that nurses used a surprising

number of personal characteristics to describe a *good nurse*. Davis (1991) reported the importance of nurses' personal values and beliefs in constructing their code for nursing practice. Understanding the effect of individual beliefs and values was found to be an important factor in the nurse's ability to manage patients' cancer pain (Taylor, Ferrell, Grant, & Cheyney, 1993). Finally, Oberle's (1993) research on nurses' moral reasoning found the nurses' view of a situation "was determined by her knowledge, attitudes, and values, that is, by 'nurse as person,' rather than by an agreed-upon professional ethic" (p. 1).

Problem Statement

Healthcare ethics research alludes to the presence of descriptive and normative personal characteristics within the person/nurse as moral agent. Further research is needed to determine the importance and relationship of these traits in influencing the person/nurse as moral agent.

Theoretical Model

An adaptation of Orem's Self Care Deficit Theory is used to explain the relationship of personal normative and personal descriptive characteristics to the person/nurse as moral agent. Orem's conceptualization of nursing agency is further specified to become nursing moral agency. Nursing moral agency, or the person/nurse as moral agent, is central, and as such acts within the context of the (a) nurse role set and the (b) situation.

Several factors affect the person/nurse's moral agency. The first is moral development, a capacity that exists within the structure and form of moral decision-making and moral behavior (Aristotle, trans. 1954; Gilligan, 1982; Kohlberg, 1984; Rothman, 1980). Kohlberg contends that moral reasoning is stage-related and follows Piaget's three-stage model of intellectual development, including pre-conventional, conventional, and post-conventional stages of reasoning. A second influence is that of personal normative characteristics, also known as foundational dispositions (Orem, 1995), or virtues (Aristotle, trans. 1954; Kohlberg, 1984). Personal descriptive characteristics that Orem terms *basic conditioning factors* comprise the third factor to affect the person/nurse as moral agent. These personal descriptive characteristics can include age, gender, family structure, socioeconomic status, patterns of knowing, and developmental stage. In summary, the person/nurse's stage of moral development, personal normative characteristics, and personal descriptive characteristics cluster to affect and influence the person/nurse's ability to act as a moral agent.

The final step in understanding how the person/nurse as moral agent functions occurs when moral development, personal normative characteristics, and personal descriptive characteristics converge to enable the nurse to act ethically. Moral agency is required for ethical behavior and is evident in the nurse's moral reasoning. The person/nurse acts as a moral agent both in the personal life action domain and the nursing action domain, yielding personal ethical behavior and professional ethical behavior, respectively. The process of ethical decision-making is evident in both personal and professional behavior. Finally, factors affecting agency and the moral act itself are influenced by the context of the situation.

Theoretical Background

The notion of person/nurse as moral agent is built upon two larger theoretical frameworks. The first is that of Aristotle and Kohlberg. The second is Orem's self-care deficit theory as it incorporates nursing ethics (Taylor & Godfrey, 1999).

Kohlberg begins with Aristotle's work in the Posterior Analytics and the Nicomachean Ethics, and continues with his own interpretation of Aristotle's view. For Aristotle, "[A]ll instruction given or received by way of argument proceeds from pre-existent knowledge" (Posterior Analytics, 1:71, Oxford translation). All knowledge is pre-existent knowledge, and embedded within this knowledge is the notion of an ideal, or a telos. One comprehends the ideal through reason and sensation. All ideals, or virtues, "involve a rational principle" (Nicomachean Ethics, VI:13). Kohlberg (1984) takes a position that he admits is in broad agreement with Aristotle. "Rational moral judgment is necessary but not sufficient for moral conduct" (Kohlberg, 1984, p. 514). For Aristotle, moral learning or development increases through both habitual exercise—*doing the good*—and through reasoning. Kohlberg quotes Aristotle: "Moral purpose is more than volition. There are things that are voluntary, that are not purposed. Moral purpose implies reason and thought, it indicates previous deliberations" (Nicomachean Ethics, III: 4, as cited in Kohlberg, 1984, p. 514). The sense of *doing* ethics, the idea that an ideal exists and one developmentally advances toward that ideal, and the necessity of reason in the process—these components of Aristotle's philosophy are integral to Kohlberg's conception of moral development.

Kohlberg (1984) summarizes his theoretical points regarding moral judgment and moral action:

1. An understanding of an actor's reasoning is a necessary condition for explaining moral action.
2. Moral situations are defined by the actor in terms of specific rights and duties attendant to that situation.
3. Moral action is determined not only by judgments of . . . justice but by follow-through judgments of responsibility in a particular situation. (p. 555)

In summary, Kohlberg's framework for moral judgment and moral action begins with Aristotle's notion of the ideal, the sense of incremental progress toward that ideal, and the need to deliberately contemplate moral reasoning and action. Kohlberg then uses his structuralist background to modify Aristotle's ideas in terms of the structure and form of moral reasoning, action, and development.

A second framework is needed to fully explain ethical considerations particular to the nurse. Taylor and Godfrey (1999), using Orem's Self-Care Deficit Theory, explained how nursing ethics impacts the nurse-patient relationship within the technological nursing system. Specific to this study is the addition of the moderator variables, which are: moral development (Kohlberg, 1984), the situational dimension (Fazio & Roskos-Ewoldsen, 1994; Rothman, 1980) and personal normative characteristics (Aristotle, trans. 1954; Davis, 1991; Kohlberg, 1984; Oberle, 1993; Rothman, 1980; Smith & Godfrey, 1999; Taylor et al., 1993). Further research may lead to examining the strength of these moderator variables and their resultant effect on the ethical behavior of the nurse.

Purpose of the Study

The purpose of the research was to examine relationships among personal normative characteristics, personal descriptive characteristics, and ethical behavior of nurses in practice. The personal descriptive characteristic variables selected were (a) age, (b) years in nursing practice, (c) educational preparation, and (d) practice setting. The personal normative characteristic variables selected were the moral attitudes of (a) integrity, (b) work ethic, and (c) reliability. The ethical behavior variable was a measure of nurses' ethical reasoning.

Research Questions

The specific research questions were: (1) Are age, years of nursing practice, educational preparation, and practice setting related to integrity, reliability, and work ethic of nurses? (2) Are nurses' integrity, reliability, and work ethic related to their ethical reasoning? and (3) Are age, years of nursing practice, educational preparation, practice setting, nurses' integrity, nurses' reliability, and nurses' work ethic related to ethical reasoning of nurses?

CHAPTER 2

Review of Literature

The purpose of this review is to conduct an integrated review and analysis of virtue ethics in healthcare and nursing ethics research where the respondents are practicing nurses. Cooper (1982) defines an integrative review as a "synthesis of separate empirical findings into a coherent whole" (p. 291). Integrative review in nursing expands Cooper's definition to include "historical, experiential, and scientific contexts relevant to the topic of study (Munhall & Boyd, 1993, p. 11). Philosophic and theoretical knowledge is critical to understanding the body of knowledge constituting virtue ethics. As such, the first part of the review was constructed to analyze philosophical, theoretical, and research contributions in the field of virtue ethics in healthcare, with specific attention to the place of virtue ethics in nursing practice. The second portion of the review will examine and analyze nursing ethics research where the respondents are practicing nurses. The objectives of the review are to present, analyze, and synthesize published work and to suggest directions for further research.

Virtue Ethics

Method

Literature sources for this review included studies and theoretical work on virtue ethics published between 1982 and April 1998. Published works cited in the review were obtained from the bioethics file of the National Library of Medicine's Interactive Retrieval Service, requested through the Kennedy Institute of Ethics, Georgetown University. The Kennedy Institute of Ethics functions as an arm of the National Library of Medicine in maintaining Bioethicsline, an on-line computer database. A search of the

terms *virtue* and *medical ethics* and *virtue ethics in nursing* revealed 286 and 26 sources respectively. A search of *virtue* and *nursing* in CINAHL from 1982 to April 1998 revealed five additional research reports.

Results

One hundred and thirty three sources were reviewed and analyzed. One hundred and ten articles were found in the medical and allied health literature. Twenty-three appeared in the nursing literature. Nurses authored 27 papers, of which five were empirical studies. Findings from one unpublished nursing study and one research report from the medical literature were included, totaling seven empirical studies for review. Philosophical and theoretical materials comprised the majority of work reviewed.

Discussion

Philosophical foundations. As part of the larger field of moral philosophy, virtue ethical theory focuses on character. According to Aristotle, moral virtue is a state of character (Nicomachean Ethics, II.5). Virtues are located within the character of the person (Gauthier, 1997). Loewy (1997) argues that the basic issue of healthcare ethics is the character of the person, not whether or not that person comes in contact with ethical quandaries. In virtue ethics, the formation of the character determines conduct. Virtue is an "internal subjective element [that is] not ...easily accessible to the public" (Heubel, 1992, p. 200) which provides the normative standard for action. Acts cannot be understood without knowledge of the inner character and intention of the actors (MacIntyre, 1984).

Relationships occur when the moral agent acts for, or in concert with, other human beings. This can be an individual relationship, or include social and institutional

relational structures. For Kant, the notion of duty presupposes a notion of virtue (Heubel, 1992). Virtue constitutes the necessary moral strength to "overcome our contrary inclinations" (Heubel, 1992, p. 200) and perform one's duty. Heubel (1992) continues:

> If the concept of virtue is reasonable, virtue is a personal trait because it cannot be separated from the moral agent ... For example, to acquire the dexterity of a surgeon may be virtuous, but the dexterity of a surgeon is not virtue. . . . A Kantian formulation is "virtue is always in progress yet always starts from the beginning" (p. 201).

From the Greek perspective, all ethics are virtue ethics (MacIntyre, 1984). Plato and Aristotle would agree that character and values precede conduct and relationships. Values are embedded in what it is to know "the good," and are reflected in the character of the person. One seeks an excellence—a telos—in traits of character that is based on reason, not emotion, centered on practical judgment, and learned by practice (Pellegrino, 1995).

Virtue ethics focuses on the agent--on his or her intentions, dispositions, and motives. The normative standard is the good person (Pellegrino, 1995). Further, virtue is acquired, not inherited (MacIntyre, 1984). One learns by seeing what the virtuous or good person does. The theoretical basis for virtue ethics is that the person wants to do good, to be good, and to act on the good. In its purest form, virtue ethics focuses on the character and integrity of the moral agent.

However, critics argue that virtue ethics lacks a standard of reference (Loewy, 1991), evident in the circular reasoning of "the good is what a good person does." Without an accepted societal norm for the "good person," virtue ethics becomes difficult

to apply. However, some ethicists contend that the absence of a moral compass for all humans does not preclude the establishment of normative standards for professions based on the telos—or ends—of that profession (Cassell, 1986; Kass, 1989; Knight, 1995; May, 1994; Meilaender, Buchanan, Brock, Sass, & Sokolowski, 1991; Pellegrino, 1994b; Pellegrino, 1995; Truog, 1995). Authors have identified the ends or aims of medicine as the relief of suffering (Knight, 1995), responding to the universal human need for healing and wholeness (Bernardin, 1996), and the healing nature of the physician-patient relationship (Pellegrino, 1994a).

Theoretical contributions: professional virtue. Using virtue theory to construct a practice and relationship with patients that builds upon the ends of medicine significantly increases the utility of virtue ethics in healthcare. Codes, standards of practice and the like would establish mid-range virtues that could more easily be evaluated and measured. Virtue ethics in a professional context also communicates an important focus on the personhood of the agent. However, it is too simplistic to urge a complete return to virtue as a basis for medical ethics (Pellegrino, Veatch, & Langan, 1991). Virtue theory must be rooted in some prior theory of the right and good and of human nature in terms of which virtues can be defined. "The hope [for understanding the truth in bioethics] rests on the universality of the phenomena of illness and healing and on the proximate and long-term aims of medicine" (Pellegrino, 1993, p. 1162).

Meilaender et al. (1991) claim a similar epistemological foundation: ". . . [M]ost of us make vocational commitments to particular ways of life. . . . If we want to know what virtues that way of life calls for, we must simply look and see. We cannot spin them out of nature of morality itself" (Meilaender et al., 1991, p. 145). It is the covenantal

relationship that ties us to what we do (Bernardin, 1996; Carson, 1988). Much depends on the physician's character and sensitivity and profession for the virtue of beneficence (Pellegrino, 1994b). A profession is, literally speaking, "a declaration of a way of life that is specific" (Pellegrino, 1989, p. 57). Further, all socialization, regardless of profession, involves a moral dimension (Hafferty & Franks, 1994).

Finally, medicine—and by extension, nursing--is epistemologically rooted in the clinical encounter (Zaner, 1990). It is the intimate nature of the work that makes the good character so important in the physician. The physician's practice brings him to the "most intimate and consequential contacts with uniquely vulnerable people" (Zaner, 1996, p. 514). As such, specific applications of knowledge in medical practice "necessarily involve estimates about the individual patient's 'good'" (Toulmin, 1993, p. 238).

Virtue theory in healthcare. Until the 1960's ethical medical practice and decisions were based on a moralistic-paternalistic model with the physician as the chief decision-maker (van der Burg, 1997). At the end of the 19th century, "reliance on science replaced faith in character" (Goldsmith, 1997, p. 1266). The physician was the one with the knowledge. As a result of increasing participant democracy, rights literature, a changing understanding of traditional morality (Pellegrino, 1990), and an increasingly pluralistic society, a liberal model emphasizing rights and obligations emerged (van der Burg, 1997). The paternalistic model that preceded the sixties held few checks and balances. In and of itself the paternalistic model was not adequate to provide answers to particular problems in healthcare. Moreover, power resting solely with the physicians

meant that the morality failed to represent the populace. While an ethic existed, it was not the object of open critical reflection and adaptation (van der Burg, 1997).

The liberal model—with its focus on respect for persons and patient rights—emerged in response to moral pluralism. In a pluralistic society "one must settle for a secular morality which is much less content-full and which possesses less robust virtues than those that bind real moral communities" (Engelhardt, 1997, p. 167). The distinctive problem solving, "product" oriented focus allowed the application of deontological and consequentialist theory to practical situations (Pellegrino et al., 1991). It provided a common knowledge for rational discourse directed toward a particular end (Greenman, 1995). The principles of autonomy, beneficence, nonmaleficence and justice (Beauchamp & Childress, 1978) emerged as prima facie rules that provided an effective organizing framework for discussion and problem solving. These principles provided an objective and effective means for addressing dilemma ethics (Pellegrino et al., 1991).

A shift to a more comprehensive moral philosophy. While the liberal model was useful with ethical dilemmas, the overly rational, proceduralist approach (Greenman, 1995) began to show its deficits after two decades of application. The model garnered criticism in the late 1980's when competing moral theories began to challenge the primacy of the four principles (Pellegrino et al., 1991). Some authors (Beauchamp, 1996; Churchill & Siman, 1986; Engelhardt, 1997) called for a better understanding of the application of principles. Others (Jones & Vance, 1994) argued that because ethics occur in socially imbedded traditions, humans ought to articulate both what the obligations, virtues and goods of our traditions are and how they are—or at least ought to be—interrelated. Important personal, private values reflecting those traditions were needed to

counterbalance stark, highly rationalized discourse. Virtue ethics, friendship theory, casuistry, life story or narrative ethics, religious theory and political theory emerged as competing moral philosophies (Gillon, 1990).

It had become clear that healthcare ethics was not simply quandary ethics (Loewy, 1997). " Moral worth of the relationship did not depend on the outcome of the relationship, but on the immediate interaction of the doctor and patient" (DuBose, 1994, p. 53). The field of ethics could not reduce itself to the utilitarian concern for producing good. Contemporary ethics must deal with being good as well as doing good (May, 1994), and as such reflects the range of theory that can be applied. Further, there was a need to recognize the balance of tension between individual decision-making and more general ethical considerations in medical practice (Quill & Cassel, 1995). Greenman (1995) argued that the liberal model is coming to the end of its ability to persuasively address important issues such as the ends of medicine, the nature and meaning of suffering, and death and dying.

The shift from principles to a more comprehensive moral philosophy in turn created room for a broader interpretation of virtue theory. Ramsey (Carson 1988), DuBose (1994) and Bernardin (1996) advocated a covenantal style of physician-patient relationship where the model of virtue becomes one of "essential intemperance" (Carson, 1988, p. 33) of love out of which virtue arises. This differs from Aristotle's interpretation of virtue as moderation, and proposes a new interpretation of how love invokes virtue (Carson, 1988). Unlike Frankena and Hauerwas' interpretation of virtues merely as correlates of obligations or principles (Toulmin, 1993), virtues supply the "human strengths that men and women need precisely at those times when they dispute over

principles and ideals" (May, 1994, p. 77). Escaping from legalistic and procedural constraints of the principle-based model, virtues also foster compassion and moral creativity (Pellegrino, 1995).

Theoretical considerations--virtue ethics in nursing. Renewed interest in virtue ethics is mirrored in recent nursing works (Sellman, 1997). Three themes emerge from the literature on nursing and virtue ethics: (a) nursing as a moral endeavor; (b) the nurse-patient relationship as the fundamental moral unit, and (c) the meanings of being and good in nursing.

Nursing as a moral endeavor. Nursing is a moral activity that consists of doing good and avoiding harm (Gibson, 1993). Nursing requires a moral view of the person based on respect of the person in his or her totality (Fry, 1988; Gastmans et al., 1998). This respect is "fundamental to the moral demand which inspires nursing practice" (Gastmans et al., 1998, p. 46). Nurses need to articulate a moral basis for their practice (Lauder, 1994) through competent actions and excellence of character (Nelson, 1982; Scott, 1995).

Philosophic work within the discipline of nursing is in the beginning stages (Kikuchi & Simmons, 1992). Bishop and Scudder (1990), in their moral philosophy of nursing practice, argue that nursing has an inherent moral base (Bishop & Scudder, 1996). Gastmans et al. (1998) have built upon Bishop and Scudder's ideas and contend that care is a foundational normative concept within nursing.

To perfect something within themselves, moral agents need to look to their characters (Scott, 1996). Virtue ethics emphasizes the inner qualities of the nurse (Brody, 1988) and can provide insight into how the nurse ought to act in relation to the patient

(Lauder, 1994). Fealy (1995) notes that that professional caring does not come from intellectual or scientific knowledge, but from the compassion that human experiences can give another by being a certain type of person. The moral and ethical beliefs of each nurse are composed of personal and professional virtues (Cameron, 1997; Lauder, 1994) that require "theories and principles . . . as a means of thinking and self-examination" (Sarvimaki, 1995, p. 350). Cameron (1997) continues:

> Without intellectual and moral virtue, our ethical decision-making is blind, because we lack wisdom about what will lead to overall happy living for ourselves and other people. . . .From the perspective of virtue ethics, principled thinking and ethical caring alone or combined are inadequate, for they lack the core of virtue ethics, perfection of the soul (p. 35).

Sellman (1997) claims that nursing has a greater affinity for virtue ethics than is usually expressed. Davis (1990), in her work with nurses internationally, concluded: "[W]e, as nurses from very different cultures, hold some of the ethical principles as guidelines for our practice and some of the same ideas of what constitutes a virtuous nurse" (p. 686).

There are four aspects of moral knowledge in nursing (Sarvimaki, 1995): (a) theoretical-ethical knowledge, (b) moral action knowledge, (c) personal moral knowledge, and (d) situational moral knowledge. Theoretical-ethical knowledge encompasses theoretical study of moral philosophy, as well as a general, critical and reflective stance. Moral action knowledge is values and principles manifested in action. Personal moral knowledge includes the personal aspect of the human being in his or her wanting to do *good*. The fourth, situational moral knowledge, means considering the

individual characteristics of the situation when making decisions. In Sarvimaki's model, virtue ethics would fall primarily in the third category, that of personal moral knowledge.

Nurse-patient relationship as the fundamental moral unit. The practice of nursing is grounded in the dynamic, interpersonal relationship between nurse and patient (Bishop & Scudder, 1990; Liaschenko, 1993). Because of the inherent moral nature of nursing, every encounter between nurse and patient becomes a moral encounter (Gastmans et al., 1998; Kass, 1989; Salsberry, 1992). This ethical practice becomes concrete through the personal relationship between the nurse and patient (Bishop & Scudder, 1990). Ethical considerations include the "fundamental moral requirements associated with the [nurse] patient relationship such as honesty, competence, compassion, integrity, and respect for persons" (Singer, Siegler, & Pellegrino, 1990, p. 95).

Nursing practically fosters the good for persons (Fry, 1988) through the nurse-patient relationship. Compassion (Lutzen & de Silva, 1996), personal attachment (Parker, 1990), and social relationship (Fealy, 1995) help to create meaning between patient and nurse. "Good clinical practice is linked to an ethical sense of desired outcomes, and responsiveness to patient concerns and interests" (Benner, 1997, p. 54).

The meanings of being and good in nursing. "You cannot be a good nurse without being a good woman," Florence Nightingale was fond of saying (Baly, 1986, p. 25). Personality traits may lead the nurse to nursing. However, these inclinations "may not be sufficient when exposed to the conflicts inherent in healthcare" (Sellman, 1997, p. 10). Davis (1990) refers to the being and doing of nursing: ". . . [W]e all look not only at doing, but at being, not only at duties and obligations but also at virtues, not only at conduct but also at character" (p. 688). In Sarvimaki's model of moral knowledge,

morality is a way of being that presupposes moral integration, "that is, the integration of theoretical, personal situation and action knowledge" (Sarvimaki 1995: 350). Virtue and character are complementary to principles and rules for action. Klimek (1990) advocates exploring the "being of care" (p. 18). His conceptualization, though minimally developed, is that *being* is connected with the ethic of care, with care viewed as the dominant virtue within professional nursing. Further examination of theory and philosophy is needed to understand this phenomenon.

Bishop and Scudder (1996) address the meaning of being a good nurse rather than the good nurse. Being a good nurse means that the nurse's concern for patients is "integrally related to efficient, effective and attentive care which fosters the well being of my patient. Even when I am not directly concerned with my patients' well being, I am focused on ways of fostering their well-being because I am engaged in a practice with an inherent moral sense" (1996, p. 36).

Nightingale and others (Alavi & Cattoni, 1995) see the good nurse as dichotomously possessing a type of persona and practice (internal goods) and identifiable skills (external goods). Alavi and Cattoni (1995) argue that a return and recommitment to a professionalism that targets the individual nurse rather than a specific set of practices is necessary. The authors quote Margaretta Styles: "Our ability to understand and fulfill our social contract as a profession would be better served by a set of internal beliefs about nursing, rather than a set of external criteria about professions" and "the core of the nursing universe is the individual nurse and the beliefs he/she holds about him/herself and nursing" (Styles, 1987). Institutional codes of conduct rely heavily on the internal sense of the individual when outlining the specifics of ethical behavior (One clear voice,

1998). The good nurse is one in whom personal attributes and experiences have become fused with professional ones (Alavi & Cattoni, 1995; Pearce, 1953).

Research contributions. Research on virtue ethics in healthcare is limited. Three studies examined nursing students' perceptions and images of the good nurse. Kiger (1993) interviewed 24 Scottish nursing students to determine major themes in the images they held about nursing. One of five themes that emerged from the data was that of the good nurse. A cheerful countenance, caring attitude, dedication, selflessness, and dependability characterized this image. Students disagreed as to whether these traits were innate or learned, and about the degree of involvement necessary. The basic fact of working with people was, however, part of the good. Davis et al. (1990) surveyed 33 students from the first baccalaureate nursing program in the People's Republic of China. These students were asked to describe the characteristics of a good nurse and a bad nurse. Personal qualities, behavior and knowledge emerged as data categories. Personal qualities of kindness, good character, sympathetic, warm, responsible, compassionate, good morals, and gentleness were most frequently identified. Behavior and knowledge traits characteristics included high skill levels, swiftness, being willing to help, and serving people wholeheartedly using a strong nursing knowledge base. Wilson and Startup (1991) interviewed students, teaching staff, and charge nurses about the qualities required of a good student nurse. Forty-six students, 28 teaching staff and 35 charge nurses from South Wales were surveyed. The authors found that the three groups of respondents failed to share a common conception of the good nurse.

The usefulness of these findings is limited. First, all three occurred in educational settings where students were being socialized into the profession. Congruence is to be

expected. Secondly, the survey methods employed appeared to be superficial, yielding little in the way of rich qualitative data. While these results may be helpful in constructing curricula, little more is known about the fundamental requirements of the good nurse or being a good nurse from these studies. The exception is the finding in Wilson and Startup's work that little agreement exists on the qualities of a good nurse.

The four remaining studies focused on nurses in practice. Hicks' (1993) research on United Kingdom nurse managers' constructs of nurse researchers utilized descriptors of the good clinician randomly selected from a list of adjectives repeatedly emerging from beginning nursing and clinical nursing textbooks. The four adjectives randomly selected were kind, compassionate, good communicator, and reflective. Analysis of randomly selected adjectives from nursing texts added little to the comprehensive understanding sought in this review. Haggman-Laitila and Astedt-Kurki (1994) found a discrepancy in client expectations of nurses when compared with nurses' views of their own roles. The clients in this Finnish study identified personal traits such as appropriateness and kindness, just and equal treatment, and genuineness and honesty. Nurses felt they should provide holistic, health-oriented, patient-centered care. The affective and virtue-oriented nature of patient expectations could be important in defining the fundamental moral requirements of *being*—in contrast to *doing*—within nursing.

Robertson (1996) sought to determine if ethical theory was useful in describing the approaches doctors and nurses take in everyday patient care. His ethnographic study with more than twenty doctors and nurses on a Canadian medical ward revealed that while there was a common commitment to liberal and utilitarian principles among doctors and nurses, nurses placed much greater weight on virtue and relational theory

when actually applying the principles. Virtue and relationship events were voiced far more often by nurses (16 events) than by doctors (three events). The nurses' notion of beneficence was closely tied to character and morality. Gillon (1996) praised Robertson's research for attempting to evaluate moral theory using sound qualitative methodology. A strong research base is needed to further develop clinical ethics as a discipline (Singer et al., 1990).

The final research report comes from the author's collaborative research in examining 53 registered nurses' responses to Kelly's (1993) statement: "Ethical nursing is what happens when a good nurse does the right thing." Nurses answered two open-ended questions based on the statement. Content analysis revealed that the data clustered in seven categories: patient care, patient first, patient advocacy, personal traits and characteristics, professional traits and characteristics, critical thinking, and competence. The themes indicated that nurses view ethical nursing as a complex endeavor, with high value placed on the personal attributes that the nurse brings into nursing by virtue of the person he/she is. Domains of *being* and *doing* were evident in the data but did not cluster into mutually exclusive categories (Smith & Godfrey, 1999).

Generalizations and Directions for Further Research

The study of virtue ethics is well grounded in centuries of philosophical thought. Questions regarding application arise, but little can be challenged about the philosophical underpinnings of the concept. Theoretical work in healthcare ethics is relatively new, however, with the majority appearing with the advent of secular bioethics in the mid-1960's. Most of the theoretical work in healthcare has been directed toward physician-

patient relationship, with little original work presented concerning the professional ethics of the nurse–patient interaction.

Nursing is beginning to address *being a nurse* through advances in nursing philosophical thought. Bishop and Scudder, Liaschenko, Davis, and others are contributing to the body of philosophical nursing knowledge. While much has been written on ethics in the nursing literature, little in nursing ethics is actually research-supported. Nursing's preoccupation with dilemma ethics and the confusion surrounding the *ethics of care* and *care-based ethics* (McAlpine, 1996; Scott, 1996) has slowed progress in developing a more comprehensive moral philosophy for nursing practice.

Virtue ethics presents as one facet of the wider moral philosophical view within contemporary medical ethics literature. However, the need to address virtue ethics in nursing may be more pressing than simply waiting for a washover from medicine to nursing. Robertson's (1996) ethnographic work indicates that virtue ethics may be an integral part of the way nurses apply ethics in practice. More research is needed to discern what terms like *character, good,* and *being* mean in nursing practice, both to nurses in practice, and to their patients. Further, scientific work is needed to determine if Davis' (1990) assertion that nurses—worldwide—embrace the same virtues is correct. If a commonality of ethical virtues and practice can be identified, nursing will be able to claim its own in a clearer and more dramatic way. If a sense of *good nurse* drives the way nurses practice, then philosophical and theoretical concepts and resultant research is needed to help nurses understand why they practice as they do.

Virtue ethics is a part of a larger moral philosophical view within healthcare, and of growing interest in discursive nursing literature. Limited studies point to the use of

virtue ethics by nurses. Further scientific inquiry is needed to identify the place of virtue ethics in nursing practice.

Nursing Ethics Research with Nurses in Practice

Method

Literature sources for this review included research studies on nursing ethics published between 1982 and March 1999. Published works cited in the review were obtained from the Cumulative Index of Nursing and Related Literature (CINAHL). A search of the thesaurus term *Ethics, Nursing,* and *research* as a descriptor revealed 232 sources. All abstracts were reviewed. Studies that (a) used student nurses as participants and (b) examined types of ethical dilemmas were excluded.

Results

A total of 95 research articles and dissertation abstracts were included in the review. In addition, two literature reviews (Ketefian, 1989; Cassidy, 1996) were used for background regarding instrumentation.

Discussion

The review is organized into five sections: (a) how decisions are made; (b) how they are implemented; (c) values/principles in ethical behavior, (d) significance of demographic factors, and (e) instruments.

How ethical decisions are made. Qualitative studies have contributed much to the body of knowledge regarding the process of ethical decision-making in nursing. Deliberation and integration (Smith, 1996), investing and discounting self (Kelly, 1998) and choosing to be the patient's neighbor (von Post, 1996) are themes in qualitative work.

Leners and Beardslee (1997) report an overarching theme of "suffering and ethical caring: incompatible entities" in their ethnographic study of staff nurses. Awareness of the ethical dimension comes from respect for human dignity (Becker, 1991; Soderberg, Gilje & Norberg, 1997), through personal choice (Sherman, 1996), personal expression (Burns & Goodnow, 1996), the context (Shipps, 1988; Viens, 1995), and advocacy (Hatfield, 1991). The processes of ethical decision-making are varied, from defined steps (Carpenter, 1991; Edwards, 1994) to an expression of interrelated processes with varying amounts of structure (Hutchinson, 1990; Leners & Beardslee, 1997; Lutzen & Nordin, 1993; Sherman, 1996; Viens, 1995; Whitler, 1996). Qualitative findings range from the absence of an agreed-upon nursing ethic (Oberle, 1993) to the discovery of a descriptive theory of human connection (Becker, 1991). Unifying essential experiences include nurses' choice (Case, 1991), comfort (Wurzbach, 1996), the utilization of psychological defenses (Astrom, Furaker, & Norberg, 1995), suffering and ethical caring as incompatible entities (Leners & Beardslee, 1997), the importance of self (Carpenter, 1991; Oberle, 1993), and human connection (Becker, 1991).

Some researchers report that ethical decision-making is not a process, but stems from a collection of experiences and feelings that nurses use to make their moral choices (Case, 1991; Jansson & Norberg, 1989; Oberle, 1993; Webb & Bunting, 1992). Others identify a "systematic and identifiable framework" (Edwards, 1994). Emotion is a consideration (Carpenter, 1991). Ethical decision making may include responsible subversion needed to act ethically (Hutchinson, 1990). A lack of agreement among faculty made it impossible to develop a best response to the scenarios (Oberle, 1993),

perhaps indicating the complexity of the moral endeavor found by other researchers (Smith & Godfrey, 1999).

Factors found to effect ethical reasoning/ethical behavior include recurrent education (Astrom et al., 1995) and individual support (Astrom et al., 1995). There is some evidence that strong peer cohesion is inversely related to higher-level ethical judgments (Cretilli, 1994). Organizational climate (Hatfield, 1991; Taunton & Otteman, 1986), familiarity with nursing ethical dilemmas (Hatfield, 1991), and individual support from co-workers (Cretilli, 1994; Holly, 1989) are also important factors. In addition, it seems that nurses with a stronger care orientation (vs technical orientation) are more ready to take action, but have more difficulty choosing between options. Nurses use both intrapersonal and interpersonal strategies (Cretilli, 1994). Finally, the personal characteristics of the nurse and/or philosophical influences (Davis, 1989), (particularly when the nurse possesses a personalist view vs an empiricist view) seem to have some bearing on the ethical decision making process as a whole (Smith & Godfrey, 1999; Jansson & Norberg, 1989; Oberle, 1993).

How nursing ethical decisions are implemented. Empirical research regarding implementation of ethical decisions is limited. While discursive literature about nurses and ethical decision-making abounds, many decisions in health care are made without nurses' input—and nurses are left to bear the major responsibility for implementing, particularly in forgoing life-sustaining treatment (Martin, 1989). Forchuk (1991) found a difference in community and mental health nurses, in that the community nurses felt the client was the decision-maker, while mental health nurses felt they were the decision makers. Nurses identified themselves as the advocate for patients (Hatfield, 1991;

Martin, 1989; Shipps, 1988). Martin (1989) reported that while eighty seven percent of the nurses identified themselves as the patient's primary advocate, only 20% reported they would go through the chain of command outside the unit if they believed the patient was not receiving appropriate treatment. Other authors (Cahn, 1987; Millette, 1989) cite institutional constraints as a major source of nursing ethical conflict, pushing the nurse into a *moral hero* position in which he/she "is required either to act unethically or act ethically at some degree of risk (Cahn, 1987, p. 1)." Nurses were in agreement that patients should be informed in all situations, but unclear if the best thing was for the nurse to inform the patient (Shipps, 1988). Nurses reported difficulties in acting in accordance with their ethical reasoning and feelings without a support group in which to share their thoughts (Astrom, Jansson, Norberg, & Hallberg, 1993).

Whitler (1996) reported the lack of congruence between making decisions and employing them. Oberle (1993) noted that twelve nursing faculty were unable to determine a "best response" to ethical situations tested in two previous phases of the study. Nurses with a care orientation may be more ready to take action, but at the same time they have more difficulty choosing between options (Burns & Goodnow, 1996). Raines (1992) found that there was a "lack of congruence between the values the nurse identifies as important and the actions the individual implements in practice" (p. 1). This is linked to the feeling of powerlessness (Erlen & Frost, 1991) experienced by nurses as they balance the role of professional and the role of employee. Also echoed by Turner et al. (1996) is the conflict between personal values and professional responsibility.

The importance of values and principles in nurses' ethical decision-making.

Historical ethical/moral themes in nursing literature can be classified into eight value

categories: well being, wealth, skill, enlightenment, power, respect, rectitude, and affection (Stiner, 1989). Stiner (1989) found that *rectitude* was the predominant value for the 1900's and 1910's, respect for the 1920's, 30's and 40's, and *well being* for the last three and a half decades, 1950-1980's. Findings vary about care/justice/principles orientations to ethical nursing. Alternately, research points to: the dominance of a principle based ethic of nursing (Corley & Selig, 1994; Kyriacos, 1995); no difference (Woods, 1993); a combined approach (Sherblom, Shipps, & Sherblom, 1993); an interdependence (Cooper, 1991); all of a whole (Jansson & Norberg, 1992); a care dominance (Millette, 1994; Keyser, 1989), and one report of an inverse relationship between ethical decision-making and autonomy based on nurses' principled reasoning (Hatfield, 1991). Liaschenko (1993) argues that morality and philosophy in nursing practice goes beyond principles and care to rest upon the idea of nurses bearing witness to lives and giving testimony.

Beneficence was stressed by all nurses in the Norberg et al. (1994) study. Similarly, Forchuk (1991) found the predominant principle to be that of beneficence, found in 26 of 57 cases presented. The majority of cases were solved with principles described by Veatch and Fry (1987), with only three of the fifty seven cases having no principles identified. This is consistent with Robertson's findings (1996) that nurses tend to use relational and virtue theory as the theoretical basis for implementing ethical decisions. Davis (1989) reported that the most potent variables in a study of nurses' decision-making were personal and philosophical influences. Raines (1992) found that neonatal nurses identified a hierarchy of values in their practice that reflected "doing right" first, beneficence, second, and justice, third. The major finding of the study was

the identification of the "doing right" value, which was a combination of items originally hypothesized to measure nurse autonomy, family autonomy, and beneficence. Raines argued that the convergence of these factors results in a unique dimension that represents the nurses' internal motivation or sense of duty.

Jansson and Norberg (1992) found that nurses gave priority to the ethical principle of autonomy in hypothetical situations about patients who showed refusal-like feeding behavior, but did not see the principles as separate, but all of a whole. Some studies were structured to determine if items fall into pre-determined categories (Elander, Drechsler, & Persson, 1993), yet there is some discussion that this approach is not adequate (Liaschenko, 1993). Bjornsdottir (1992) found that maintaining patient privacy was central to nurses' understanding of their work. Day et al. (1995) found autonomy, beneficence and nonmaleficence most often guided nurses decisions. Mattiasson and Anderson (1995) reported the dominant moral value was beneficence, followed by autonomy. Turner et al. (1996) found beneficence, non-maleficience, justice and patient autonomy to be core ethical principles. Soderberg et al. (1996) pointed to difficult ethical situations, in which all concerned tragedy, and invoked a spirit of compassion that pointed to values. The intention of compassion was aimed at respecting these ethical values. Communication of values meant risking vulnerability and meeting oneself. There was, however, some question about the relevance of attitudes when compared with subjective norms (Savage, Cullen, Kirschhoff, Pugh, & Foreman, 1987). Subjective norms played a greater role in hypothetical situations involving DNR orders in this research.

Demographic factors. A number of authors have examined the impact of selected demographic variables on ethical decision-making and ethical behavior. The results are mixed. Age seems to be either a positive factor (Lutzen, Nordstrom, & Evertzon, 1995), negatively related to incidences of ethical conflicts (Haddad, 1988) or to have no correlation at all (Redman & Fry, 1998; Mattiasson & Andersson, 1995). Likewise, level of education has been found to be negatively related (Haddad, 1988), not significant (Hatfield, 1991; Redman & Fry, 1998; Smith, 1989), or positively related when dealing with ethical issues (Duckett et al., 1992; Wlody, 1993; Herndon, 1993; Woods, 1993). Practice setting seemed to make some difference (Wlody, 1993; Lutzen et al., 1995), though other authors such as Redman and Fry (1998) found no difference in the responses of nurses in different practice settings. Finally, level of experience was a factor of no significance (Hatfield, 1991), a positively associated variable (Mattiasson & Andersson, 1994; Kyriacos, 1995; Lutzen et al., 1995), or negatively related to incidence of ethical problems (Haddad, 1988). No pattern is evident in this minor meta-analysis of demographic results of ethical studies in nursing.

Instruments. Authors agree that the major tools to measure moral reasoning of practicing nurses are the Crisham's Nursing Dilemmas Test (NDT), the Defining Issues Test (DIT), and the Moral Judgment Interview (MJI) (Cassidy, 1996; Dierckx de Casterle et al., 1997; Ketefian, 1989; McAlpine, Kristjanson, & Poroch, 1997). A fourth instrument, the Judgment About Nursing Decisions (JAND), was identified as the instrument used to measure ethical practice (Dierckx de Casterle et al., 1997; Ketefian, 1989). However, the findings in this review reveal that the use of these instruments with practicing nurses is very limited. The NDT was used in one doctoral dissertation

(Cretilli, 1994) and one master's thesis (Herndon, 1993). The NDT appeared more frequently, with six appearances in the literature (Corley & Selig, 1994; Cretilli, 1994; Hatfield, 1991; Kyriacos, 1995; Webb & Bunting, 1992; Woods, 1993). There were no studies that used the JAND or MJI. Several investigator-developed instruments were used in single studies (Herndon, 1993; Martin, 1989), but validity information was not provided.

One explanation for the limited use of these instruments is reported in Cassidy's (1996) review of moral competency. Scoring and interpretive issues regarding Rest's DIT (Duckett et al., 1992), reliability questions about the NDT (Corley & Selig, 1992), and an inability to discriminate levels of moral reasoning on the JAND (Oddi & Cassidy, 1994) has left nursing without reliable and valid instruments to measure ethical reasoning and ethical practice. However, two new instruments show promise. Dierckx de Casterle, Grypdonck, and Vuylsteke-Wauters (1997) have developed the Ethical Behavior Test (EBT) which uses Kohlberg's theory of moral development to test the constructs of ethical reasoning, ethical practice, and then, as a composite score, ethical behavior. Reliability and validity evidence is present in the literature, with validity for ethical reasoning, ethical practice, and ethical behavior assessed using inconsistency scores (Dierckx de Casterle et al., 1997). The second instrument is McAlpine, Kristjanson, and Poroch's (1997) Ethical Reasoning Tool (ERT). Cognitive progression, reflection (based on Habermas), and attitude theory form the theoretical basis for this instrument. Reliability and validity data met pre-set criteria in the initial study (McAlpine et al., 1997). No research using either tool with nurses in practice is present in the literature.

Conclusions

The dearth of empirical studies of ethical reasoning and behavior among nurses in practice is real. With the exception of two new tools, few researchers have used empirical instrumentation, in part due to significant psychometric and methodological questions about existing tools. The majority of works are descriptive, and for the most part primitive in nature, using superficial survey methods.

Based on scientific work in moral and cognitive psychology, (a) personal characteristics and (b) the situational nature or context are important moderators for attitudes and behavior (Fazio & Roskos-Ewoldsen, 1994; Rothman, 1980). The idea of virtue or character and its corresponding effect on ethical behavior fits well within the philosophical assumptions of psychology, philosophy, and nursing. It is hoped that by using reliable and valid ethical nursing instrumentation, this research will be among the first to empirically explore relationships among personal characteristics and ethical behavior in nursing practice.

Methodological Challenges: Character, Attitudes and Behavior

Until the last two decades scientific efforts to study character have yielded dismal results (Lapsley, 1996). The work of Hartshorne and May (1928-30), considered the classic empirical psychological research on moral character, revealed confusing and contradictory findings (Kohlberg, 1984). Despite elaborate studies, the researchers failed to find that internal dispositions predicted moral behavior (Kohlberg, 1984). Based on Hartshorne and May's work, Kohlberg (1984) concluded that their "socially relativist behaviorist approach failed (a) because it ignored the *internal* definition of moral action

content as the subject ... perceived it...and (b) because it ignored the *form* of the subjects' judgments of morality" (p. 508). Kohlberg's ideas led moral psychology into the area of *structure* and *form* of moral development—an emphasis that dominated the field from the 1960's into the early nineties. Now, with new cognitive science research on personological factors and renewed interest in virtue theory, new possibilities for research on the place of virtue or character in moral theory are emerging (Lapsley, 1996).

Clues to the overall significance of personological factors (personal characteristics), or "the sort of person one is" (Lapsley, 1996, p. 196) appear in the work on attitude strength and accessibility (Baron & Byrne, 1997), the study of effects of attitudes on behavior (Fazio & Roskos-Ewoldsen, 1994), and the ways in which moral reasoning influences moral behavior (Rothman, 1980).

Scholarly work in cognitive social psychology and personality holds the greatest promise for a comprehensive scientific appraisal of character. Instead of looking for "cross-situational consistency" (Lapsley, 1996, p. 242), it is now thought that moral responses should only be compared with prototype situations (Mischel, 1984). This is because there is evidence that how we understand persons (Cantor & Mischel, 1977; Cantor & Mischel, 1979; Chaplin, John, & Goldberg, 1988), social situations (Cantor, Mischel & Schwartz, 1982), diagnostic categories (Cantor et al., 1980), and emotions (Fehr & Russell, 1984) are organized around prototypes (Lapsley, 1996). Lapsley (1996) also notes a potential cognitive science contribution to moral psychology in the work with *chronic accessibility of knowledge*. "It is well known that the meaning and significance of persons, objects, events and situations depend on how these things are represented and categorized. The personal constructs that we use help us extract meaning

from our social experience (Kelly, 1955; Mischel, 1973). ". . .[P]erhaps it makes more sense to think of traits and virtues and character in terms of personal constructs and the knowledge structures, categories, and schemas that are chronically accessible" (Lapsley, 1996, pp. 243-244). Unfortunately this work is still in the developmental stages and the full impact on moral psychology is not yet known.

What is evident, however, is the impact of personological research on American industry. Personnel psychologists and organizational management specialists have developed a large body of pre-employment examinations called integrity tests. Over a third of a million people in companies throughout North America have taken these tests (Paajanen, Hansen, & McLellan, 1993). Sackett et al. (1989) categorize the tests into two categories: overt integrity tests, and personality-based tests. They are commercially produced (Ones, Viswesvaran, & Schmidt, 1993) and used in a variety of settings. Overell (Overell, 1998) reported that in 1996, 87% of employers used psychometric testing. In their meta-analysis, Ones et al. (1993) found that across 7,550 people, the best estimate of the mean validity for predicting job performance was .41, and 100% of the variance accounted for. In Barrick and Mount's (1991) meta-analysis of the *Big Five* personality dimensions, the conscientiousness dimension was found to be consistent in predicting job performance across all jobs tested (Sackett & Wanek, 1996). As Ones et al. (1993) comment, "The finding that selection instruments can predict externally measured composite measures of irresponsible or counterproductive behaviors with substantial validity seems remarkable" (p. 697). Further, based on additional analysis of validity data, Sackett and Wanek (1996) argue that that integrity tests are not only linked to counterproductive behaviors, but can in fact predict "more careful, persistent, and

productive workers" (p. 799). Interestingly, evidence indicates that mental ability and integrity scores are uncorrelated (Ones et al., 1993; Sackett & Wanek, 1996).

In short, work in personnel psychology offers sound testing that is able to measure attitudes about honesty, integrity, conscientiousness, dependability, trustworthiness, and reliability (Sackett & Wanek, 1996)—and can effectively predict job performance in multiple settings (Ones et al., 1993; Sackett et al., 1989; Sackett & Harris, 1984; Sackett & Wanek, 1996). Though not the virtues Aristotle identified—courage, temperance, liberality, magnificence, high-mindedness, gentleness, truthfulness, wittiness, and justice—the personological factors in Sackett and Wanek's (1996) review look strikingly like virtues of contemporary American society. The correlation to job performance—a prominent American value—further underscores the claim that (a) virtues are present in our society, and (b) that attitudes about the virtues can be accurately measured.

Despite the results of earlier studies, recent evidence indicates that attitudes do influence behavior (Baron & Byrne, 1997). The strength of the attitude-to-behavior link is moderated by (a) aspects of the situation, (b) aspects of the attitudes themselves, and (c) the personal characteristics of the individuals who hold them (Fazio & Roskos-Ewoldsen, 1994). *Attitude origin, attitude strength,* and *attitude specificity* pertain to the personal characteristics of the individual involved. Direct experience often exerts stronger effects on behavior than those obtained through hearsay (Baron & Byrne, 1997). There also appears to be a connection between an individual's *self-monitoring* ability and the strength of the attitude behavior link (Ajzen, 1988). Further, by implementing Ajzen and Fishbein's (1980) theory of reasoned action, it is suggested that the best predictor of

how we will act in a given situation is the strength of our intentions with respect to that situation (Ajzen, 1988).

Therefore it can be argued that attitudes influence behavior—and at times can strongly influence behavior (Baron & Byrne, 1997). But how can attitudes and behavior be reflective of character? Malerstein and Ahern (1982) consider the structure of character to be "the most stable aspects of a person as a social being" (p. 8). As such, character reflects a person's most fundamental nature. Erikson (1964) separated moral ideas from virtues, saying that moral ideas needed the qualities of character to "animate them, give them spirit, root them deeply in personality" (Shields & Bredemeier, 1995, p. 193). As social beings, humans communicate on many levels, using a myriad of communication methods. Attitudes are only one way—albeit an important, and from a social science viewpoint, a measurable way—that humans communicate their foundational dispositions, or character, to others.

CHAPTER 3

Method

Sample

The sample consisted of registered nurses with at least six months' nursing experience who were employed as direct patient care providers in one of three practice settings in a Midwestern metropolitan area. Practice settings included a medium-sized urban hospital, a suburban hospital, and a rural hospital. A computer-generated list of random numbers was used to select nurses in the two larger institutions; all RN's in the rural hospital constituted the potential rural sample. Table 1 is a listing of the number of potential nurses selected and contacted.

Table 1. Potential Participants in Each Practice Setting

	Setting		
Number of nurses	Urban hospital	Suburban hospital	Rural hospital
Meeting study criteria	n = 199	n = 263	n = 53
Randomly selected	n = 70	n = 70	NA
Contacted	n = 49	n = 62	n = 43

Sample Size

A sample size of at least 30 from each hospital, or a total of 90 participants, was needed due to the number of predictor variables in the proposed regression model

(Harrell, Lee, & Mark, 1996). A total of 154 registered nurses were contacted in person by the researcher and asked to participate in the study. The agreement rate was 97.4%, with 150 of the 154 potential participants assenting. Of 150 questionnaires distributed, 139 (92.7%) were completed and returned. Eight (5.8%) of the returned questionnaires had incomplete data or failed to meet the study criteria. The remaining 131 completed questionnaires were included in the analyses.

Descriptive Data

Of the 131 participants, 120 were female and 11 were male. There were 39 nurses from the urban hospital, 53 from the suburban hospital, and 39 from the rural hospital. Ninety-two participants (70.2%) were employed full-time, with the remaining 39 employed part-time (12.2%) or PRN (17.6%). The majority of participants ($n = 56$) had a BSN, and three had Masters' degrees. Because of the low number of participants with masters' degrees, those participants were added to the BSN group for statistical analysis.

The participants' mean age was 42.7 years ($SD = 10.22$), similar to the 42.3 average age of all RN's employed in nursing (Survey of American Nurses, 1999). Nurses employed in the rural hospital setting were slightly older and had slightly more experience (see Table 2). The mean years in nursing practice was 14, ranging from 1 to 41 years.

Table 2. Nurses' Age and Years of Nursing Practice by Practice Setting (N = 131)

Nurses	*n*	*Mean*	*SD*	*Range*
		Age in Years		
Practice Setting				
Urban	39	42.4	10.6	24 - 59
Suburban	53	41.1	10.5	23 - 64
Rural	39	45.2	9.0	22 - 63
		Years in Nursing Practice		
Practice Setting				
Urban	39	14.5	9.6	1 - 39
Suburban	53	13.1	10.3	1 - 40
Rural	39	17.4	11.6	2 - 41

Instruments

Three instruments were used: (a) Demographic Data Form, (b) The INSURE Survey™, and (c) The Ethical Behavior Test (EBT).

Demographic Data Form

The Demographic Data Form was designed to collect information regarding age, educational preparation (Associate Degree in nursing, Diploma, BSN, Master's degree, and other), years in nursing practice, employment status (full-time, part-time, PRN), gender, and practice setting (rural, urban, suburban). The Demographic Data Form appears in Appendix A.

The INSURE Survey™

This instrument is a combination employment interview and attitude assessment instrument. Section II contains a 124-item assessment of attitudes measured on a five-point Likert scale designed to measure attitudes about integrity, substance abuse, reliability, and work ethic. The INSURE Survey™ is part of a psychological testing package offered by Advanced Psychometrics, Inc., San Antonio, TX for use in pre-employment screening.

Factor loadings and communality estimates from an original factor analysis study of industry employees using principle components estimation method with varimax rotation were used to determine items on each scale that best represented that particular factor (Johnston, 1996). Age and race variables were analyzed using one-way analysis of variance and Scheffe post hoc procedures on each scale of the INSURE Survey™ instrument. Johnston (1996) and McCallon and Schumacker (1996) reported that the Cronbach's alpha reliability coefficients on each subscale ranged from .84 to .87. Evidence of validity of the INSURE Survey™ was based on the outcome of a study by McCallon and Schumacker (1996). A group of 411 industry employees who had been on the job for at least one year and who were rated as superior in each of the four targeted areas were asked to complete the INSURE Survey™. Validity was examined by comparing the performance of a contrasted group of 210 recent prison parolees with the norming (employee) group. Evidence of validity was obtained when parolees were found to score significantly lower on each of the four subscales when compared to the norming group. Section II of the INSURE Survey™ appears in Appendix B.

Integrity scores on the INSURE Survey™ reflect attitudes about adherence to moral and ethical principles acceptable in the workplace. Reliability scores indicate attitudes toward tardiness and personal dependability that are acceptable in the workplace. Work ethic scores reflect belief in the value of work and supervisory relationships acceptable in the workplace (Johnston, 1996). Only Section II of the INSURE Survey™ was administered. Substance abuse findings were not reported. Participants used a paper and pencil version of the instrument and indicated their responses by circling their choice for each item using a five-point Likert scale (1-strongly agree, 2-agree, 3-uncertain, 4-disagree, and 5-strongly disagree). Data from paper and pencil tests were entered into the PC-based INSURE Survey™ scoring program. A score between 1 and 9 was generated for each attitude, with higher scores indicating stronger attitudes.

Ethical Behavior Test (EBT)

The Ethical Behavior Test (EBT) is a test developed to measure the ethical behavior of nurses and nursing students (Dierckx de Casterle et al., 1997). Modeled after the Nursing Dilemmas Test (NDT) and the Defining Issues Test (DIT), the EBT consists of five dilemmas common to nursing practice. Kohlberg's moral development theory, adjusted by incorporating a care perspective (based largely on Gilligan's (1982) work) provided the theoretical basis for the instrument (Dierckx de Casterle, Roelens, & Gastmans, 1998).

The authors of the EBT assessed reliability of ethical reasoning (ER) in two ways (Dierckx de Casterle et al., 1997). First, congruence between (a) evaluation of importance of each argument and (b) ranking of the five arguments was assessed.

Participants were asked to assign a value to each argument and then rank each according to its respective value. Dierckx de Casterle et al. (1997) found that between 94% and 96% of the items ranked first received the highest value and that between 93% and 94% of the items ranked second received the highest or second highest value. Secondly, consistency in the ranking of the five dilemmas was examined, and inconsistency scores were calculated. Rest (1976) suggests that inconsistencies in ethical reasoning diminish as subjects progress in their development (Dierckx de Casterle et al., 1997). Therefore it could be expected that the inconsistency scores would decrease as the ER score of the subject increased. The authors report a "small negative but significant influence on the inconsistency score (N = 2804)" (p. 96). This finding suggests that the probability that a participant will reason in a similar manner in different situations somewhat increases (and inconsistency scores decrease) as the participant is capable of higher levels of moral reasoning.

Evidence supporting construct validity of the instrument was based on the extent to which the participants' patterns of ethical reasoning corresponded to Kohlberg's theoretical insights about ethical reasoning and action. According to Kohlberg, the average young adult has reached the third level of moral development and most probably could be located in the fourth stage. The authors constructed response options that reflected Kohlberg's stages 2 through 6. The degree to which the answers corresponded to the stage constituted the basis for scoring. Inconsistency scores were re-calculated for each stage across dilemmas to determine the deviation of the rank of the arguments belonging to a stage from the mean rank of that stage. Dierckx de Casterle et al. (1997)

found that responses varied somewhat with different situations, and that overall the patterns of ethical reasoning scores were congruent with Kohlberg's theory.

Further validation of ethical reasoning was examined using contrasting groups technique. The responses of 59 Belgian expert nurses were compared with those of Belgian student nurses (N = 2742) in three different educational programs. Pair-wise analysis of the mean ethical reasoning scores showed that each group—technical students, professional students, university students, and expert nurses--significantly differed from the other groups (Dierckx de Casterle et al., 1997; Dierckx de Casterle, 1999).

The EBT measures two components of ethical behavior: ethical reasoning and ethical practice. Only the ethical reasoning portion of the EBT was used in this study. Participants were asked to read each of the five dilemmas and respond to questions regarding (1) the course of action to be taken, (2) the importance of five arguments in justifying the course of action, and (3) the rank ordering of the justifying arguments. The EBT appears in Appendix C.

Procedure

Written permission to use the instruments was obtained from the authors of the EBT and the INSURE Survey™. Since the EBT was only available in Dutch, an expert fluent in Dutch and English translated the instrument into English. Per the instructions of the EBT's first author (Dierckx de Casterle, 1999) three nursing experts independently evaluated the English instrument for relevance to American nursing culture. Appropriate revisions were made. The EBT was then back-translated to Dutch and submitted to the EBT author for evaluation from a methodological and content perspective. The author

responded with feedback regarding clarity and congruence with original intent of the instrument. Most of the revisions were editorial in nature, incorporating wording changes that would more accurately reflect the intent of the original EBT. Revisions were made, and a copy of the revised instrument was sent to the author.

Approval by the University of Missouri Health Sciences Institutional Review Board was obtained (Appendix D), as well as written permission from the nursing administrative officer of each participating institution. Lists containing names of RN employees working in direct patient care with at least six months experience were requested and obtained. Random numbers were assigned to RN names on the urban and suburban hospital lists, and 70 names were randomly selected. All RN employees meeting the criteria comprised the rural hospital sample (n = 53).

Each potential participant received a letter (Appendix E) via in-hospital mail regarding selection, participation, and upcoming personal contact by the researcher within two weeks of receipt of the letter. Staffing specialists at each institution provided scheduling information so that personal contact could made. Contacts began within one week of letter delivery; all contacts were completed within three and a half weeks. The initial contact consisted of a five to seven minute introduction to the research, followed by a request to participate. The response burden of 30 to 45 minutes was explained. A script for the personal contact appears in Appendix F. After agreeing to participate in the study, the participant was given a research packet containing an introductory letter (Appendix G), a card to complete to receive study results, Demographic Data Form, Section II of the INSURE Survey™, the Ethical Behavior Test (EBT), and a stamped envelope for data return. Features of the questionnaires were discussed. Specifically the

appearance of a letter-number code (e.g., A-35) in the lower right hand corner of both the return envelope and questionnaire packet was explained, and personal anonymity was assured. Participants were informed that the numbering system was used to identify when a particular participant returned the survey, but that upon return the questionnaires were stapled and grouped according to institution, excluding any personal identifying information. A label identifying the packet as "Attitudes and Ethical Behavior Survey" with a line stating "Return by_____" appeared on the outside of the research packet. A total of sixteen follow-up phone calls were made to participants who had not returned questionnaires. All participants received a thank you note and a lapel pin inscribed with Nursing: Healing from the Heart (value: $0.91). Ninety-two nurses returned cards requesting copies of the study results.

Ethical Considerations

Institutional consent was obtained from the Health Sciences Section of the University of Missouri Institutional Review Board prior to data collection. Confidentiality was assured both during the initial contact and in the letter explaining the data collection procedures. All participants were treated in accordance with the Guidelines for Scientific Integrity (Midwest Nursing Research Society, 1996). Surveys were coded to enable follow-up, but the list of participants was known only to the researcher and was kept separate from the survey data. Participants' addresses and phone numbers were destroyed upon completion of the research. Data were kept in a locked file cabinet in the researcher's office. Assurances were communicated to the nurses that participation was voluntary and could be withdrawn at any point without repercussion.

Participants were assured that no individual results would be shared. No survey was associated with the participant except to determine those who agreed to participate but did not return the survey data. Only aggregate data were reported.

Planned Data Analysis

Raw data from the Demographic Data Form, INSURE Survey™, and EB will be double-entered in an Excel database program and exported to a SAS statistical program for analysis. Data will be analyzed for errors and corrections will be made in both data sets using original data sheets, yielding 100% correspondence in both data sets.

Initially, three Kruskal-Wallis analyses of variance will be used to determine if the integrity, reliability, and work ethic variables differ across the three levels of the categorical variable educational preparation (AD in Nursing, Diploma, and BSN/MSN), or differ across the three levels of the categorical variable practice setting (urban, suburban, and rural). Secondly, Spearman Rank Correlation coefficients will be calculated to examine the relationships among age and years in nursing practice, and integrity, reliability, and work ethic variables. Third, three stepwise multiple regressions will be conducted to determine if educational preparation, practice setting, age, and years in nursing practice could predict integrity scores, reliability scores, or work ethic scores. Finally, a fourth stepwise multiple regression will be conducted to determine if educational preparation, practice setting, age, years in nursing practice, integrity scores, reliability scores, or work ethic scores could predict ethical reasoning (ER) scores. Alpha was set at $p = .05$ for planned analyses.

CHAPTER 4

Results

Descriptive Statistics

The mean scores and ranges for the integrity, reliability, and work ethic variables are shown by educational preparation and practice setting in Tables 3, 4, and 5, respectively. Sample means for integrity, reliability, and work ethic scores were 4.5 (*SD* =1.34), 5.3 (*SD* = 1.62), and 5.6 (*SD* = 1.59). On average, nurses in this study had scores of 4 or above for integrity and 5 or above for both reliability and work ethic, indicating they possessed attitudes desired and rewarded in the workplace (Johnston, 1999).

Table 3. Participants' Integrity Scores by Educational Preparation and Practice Setting (N = 131)

Integrity Scores	*n*	*M*	*SD*	*Range*
Educational Preparation				
AD in Nursing	45	4.9	1.62	1 - 9
Diploma	27	4.4	1.05	3 - 7
BSN/MSN	59	4.1	1.13	1 - 8
Practice Setting				
Urban	39	4.5	1.23	1 - 7
Suburban	53	4.3	1.38	1 - 9
Rural	39	4.5	1.41	3 - 9

Table 4. Participants' Reliability Scores by Educational Preparation and Practice Setting (N = 131).

Reliability Scores	*n*	*M*	*SD*	*Range*
Educational Preparation				
AD in Nursing	45	5.6	1.45	1 - 8
Diploma	27	5.3	1.76	1 - 8
BSN/MSN	59	5.1	1.6	1 - 8
Practice Setting				
Urban	39	5.2	1.58	2 - 8
Suburban	53	5.3	1.45	1 - 8
Rural	39	5.3	1.92	1 - 8

Table 5. Participants' Work Ethic Scores by Educational Preparation and Practice Setting (N = 131).

Work Ethic Scores	*n*	*M*	*SD*	*Range*
	Educational Preparation			
AD in Nursing	45	5.7	1.63	1 - 9
Diploma	27	5.7	1.41	3 - 8
BSN/MSN	59	5.5	1.65	1 - 9
	Practice Setting			
Urban	39	5.6	1.69	1 - 9
Suburban	53	5.8	1.43	1 - 8
Rural	39	5.4	1.71	1 - 9

Initial Data Analysis

In the initial analysis of the data, none of the personal descriptive or personal normative variables predicted ER results. It was expected that some of the personal descriptive variables would predict ER scores (Duckett et al., 1992; Haddad, 1988;

Herndon, 1993; Kyriacos, 1995; Lutzen, Nordstrom, & Evertzon, 1995; Mattiasson & Andersson, 1994; Wlody, 1993; Woods, 1993). Further investigation was needed.

Given the lack of meaningful bivariate correlations between each of the personal descriptive variables and ER scores, and attention was drawn to possible methodological explanations. A second look at the sample and procedure yielded few clues. The mean age and educational distribution of the hospital-based nurses closely resembled national findings (America's RN Today, 1999). Participants were randomly selected in the case of the larger hospitals, and the total population was used in the rural hospital. The sample size was adequate for the proposed methods of analyses (Harrell, Lee, & Mark, 1996). Response rate for questionnaire return was high (92.7%), and free of coercion. Procedures were followed as projected, with confidentiality and truthfulness upheld in each step of the research process.

The remaining explanation for the lack of relationship between normative and descriptive characteristics and ER scores was related to instrumentation or measurement error. Because the EBT provided the measure of ethical reasoning in this study, a more careful examination of the EBT's ability to accurately measure ethical reasoning was warranted.

To gather additional evidence of validity, a contrasted groups technique was applied using an additional sample of beginning baccalaureate nursing students. Approval for the additional sample was granted through the Health Sciences Section of the University of Missouri Institutional Review Board. The student group (N = 76, M = 41.94, SD = 5.4) was compared with the nurses group (N = 131, M = 42.68; SD = 5.4)

using an independent t test (t (1, .05) = 0.717, $p \leq .39$. There was no statistically significant difference between the two groups.

Failure to provide evidence for the claim of ER validity meant that any interpretation of ER results would be speculative and unfounded; therefore, no further ER results are reported.

To determine if integrity, reliability, and work ethic mean scores differed across the three levels of educational preparation and the three practice settings, six Kruskal-Wallis Analyses of Variance were performed (see Table 6). The outcome of the data analyses indicated that integrity scores differed significantly across educational groups (X^2 (2, N = 131) = 9.35, p = .009). Specifically, the AD in nursing group had significantly higher integrity scores than the BSN/MSN group (Tukey's HSD (128, .05) = 3.35; minimum significant difference = .70). None of the remaining five analyses indicated any statistically significant differences.

Table 6. Kruskal-Wallis Analyses of the Effect of Educational Preparation on Integrity, Reliability, and Work Ethic Scores, and the Effect of Practice Setting on Integrity, Reliability, and Work Ethic Scores (N = 131)

Scores	X^2	*df*	$p \leq$
	Educational Preparation		
Integrity	9.35	2	0.009*
Reliability	1.60	2	0.449
Work Ethic	0.61	2	0.738
	Practice Setting		
Integrity	1.41	2	0.494
Reliability	0.74	2	0.690
Work Ethic	1.45	2	0.485

*$p \leq .05$

Spearman Rank Coefficients were then calculated to examine the relationships between the two remaining independent variables, age and years in nursing practice, and the three dependent variables, integrity, reliability, and work ethic. Results are presented in Table 7. As may be seen, correlations ranged from 0.00 to 0.11. No statistically significant correlations were obtained. The highest correlation coefficient found was between integrity scores and years of nursing practice ($r = 0.13$, $p \leq 0.18$). Essentially, these six correlation coefficients suggest no relationships or associations between

educational preparation and integrity, reliability, and work ethic scores, and between practice setting and integrity, reliability, and work ethic scores.

Table 7. Spearman Rank Correlation Coefficients between Age and Integrity, Reliability, and Work Ethic Scores, and between Years in Nursing Practice and Integrity, Reliability, and Work Ethic Scores (N = 131)

Variables		Age in Years	Years in Nursing Practice
Integrity			
	r	0.15	0.13
	$p \leq$	0.09	0.18
Reliability			
	r	0.11	0.15
	$p \leq$	0.22	0.07
Work Ethic			
	r	0.00	0.05
	$p \leq$	0.99	0.53

*$p \leq .05$

Data analyses reported earlier were used to determine which variables were to be used in the subsequent analyses. For instance, educational preparation was redefined as an indicator variable, AD in Nursing, based on its significant effect on integrity scores. A second indicator variable for Diploma category of educational preparation was also identified. The practice setting variable was not included because it was not statistically

related to any of the dependent variables in earlier analyses. Age, years in nursing practice, AD in nursing as an indicator variable, and diploma as an indicator variable were added in the three stepwise regression procedures. These procedures were used to examine the ability of age, years in nursing practice, educational preparation, and practice setting to predict integrity, reliability, and work ethic scores.

As seen in Table 8, variables AD in nursing and years in nursing practice significantly predicted integrity scores. None of the independent variables--age, years in nursing practice, or educational preparation--significantly predicted reliability or work ethic scores in the subsequent two regressions.

Table 8. Summary of Stepwise Regression Analysis for Variables Predicting Integrity Scores (N = 131)

Variable	Parameter Estimate	*SE*	*F*	*P* ≤
Step 1				
AD in Nursing	0.67	0.24	7.94	0.056*
Step 2				
Years in nursing Practice	0.02	0.01	4.54	0.035*

*p ≤ .05. Note: R^2 = .05 for Step 1; R^2 = .09 for Step 2 ($p \leq .05$).

Because AD in nursing and years of nursing practice both significantly predicted integrity scores, an additional regression analysis was conducted to determine if the interaction of the two variables was responsible for the significance. A third variable, AD in nursing and years in nursing practice (AD AND YRS), was created. When the

variables of AD in nursing and years of nursing experience were added to the model along with AD AND YRS (see Table 9), only the newly created variable significantly predicted integrity scores ($F(3, 127) = 5.99$, $p \leq 0.0007$). The integrity scores for individuals with an AD in nursing tended to increase with increasing years of experience.

Table 9. Summary of Stepwise Regression Analysis for Variables Predicting Integrity Scores with a Third Variable, AD in Nursing and Years in Nursing Practice (AD AND YRS) Added (N = 131)

Variable	Parameter Estimate	*SE*	$p \leq$
AD in Nursing	-0.06	0.42	0.88
Years in nursing practice	0.01	0.01	0.36
AD AND YRS	0.05	0.02	0.02*

*$p \leq .05$. Note: $R^2 = .124$.

CHAPTER 5

Discussion

Character

The public rates nurses as the most trusted occupational group ("Morgan Pool on ethics and honesty as judged by people--1998"). However, empirical assessment of the character of nurses is complicated. This research attempted to measure character by examining work-related moral attitudes. Based on the findings, nurses could well deserve the public trust: with average scores of 4 for integrity and 5 for reliability and 5 for work ethic on the INSURE Survey,™ nurses exhibit attitudes desired and rewarded in the workplace (Johnston, 1999).

However, study results also raise an important question about the public trust. If nurses embody such valued traits, and their attitudes represent those favored in the workplace (Johnston, 1999)—why did the nurses' scores reflect the lowest score of the acceptable range (4 and above for integrity, 5 and above for reliability, and 5 and above for work ethic)? One explanation may be found in the context of the instrument itself. Since the INSURE Survey™ focuses on the workplace, lower scores may reflect tension between professional nursing values and the actual work environment. In this era of deteriorating attitudes among hospital employees (Gilliland, 1997), nurses may feel that to best serve patients they must act outside the institutional structure. Moral distress—knowing what should be done, and being kept from doing so because of institutional obstacles--is a documented phenomenon among nurses and other healthcare professionals (Corley, 1995; Hefferman & Heilig, 1999). Nurses may find that in order to act in

accordance with their professional value systems, they must be subversive in the institutional arena.

Such an attitude may not be limited to nurses. Coleman (1999) reported that 58% of the physicians surveyed would consider it ethical to lie to an insurance company or HMO if patients cannot get treatment any other way. In addition, most physicians in the study (76%) believed their primary professional responsibility was to practice as their patient's advocate. Given that integrity is defined in this study as "attitudes about adherence to moral and ethical principles in the workplace" (Johnston, 1999, p. 1), the low scores may reflect ethical distress in the healthcare environment. Future investigators may wish to explore the relationships between integrity and ethical distress in light of these environmental stressors.

This line of reasoning may also offer clues to the otherwise puzzling findings regarding the significant increase in integrity scores in associate degree prepared nurses with increasing years of nursing experience. One could speculate that these findings might reflect yet another difference in associate degree nursing education when compared with diploma or BSN educational preparation. It also may be based upon personal differences in associate degree nursing graduates that are unique to their choice of educational preparation. Finally, the personal experiences AD nursing graduates bring to the workplace may reflect a greater respect for and congruence with workplace norms, and in particular to those ethical and moral principles already in place. AD graduates are often more practical in nature, having often had more life experiences before entering school. A willingness to accept the bureaucratic structure and work within it for change may actually be more prevalent within that educational group. This is in contrast to a

baccalaureate emphasis where assertiveness, autonomy, and patient advocacy are strongly encouraged—even to the point of leaving untenable work situations. It stands to reason that the autonomous professional could have greater conflict with institutional norms than the nurse who is more socialized to survive within the system *as is*. In any case, as Duckett et al. (1992) argue in their critique of nurses' moral reasoning research, "Education is a critical variable, and the educational mix within nursing is an historical artifact that must be recognized" (p. 329). The results of this study call for a more careful look at the outcomes of the three types of registered nurse preparation: AD in nursing, Diploma, and BSN.

Ethical Reasoning

In contrast to the lack of empirical work regarding nurses' character, a number of studies reported findings about nurses' moral reasoning. Most of the studies focused on nursing students' ethical or moral reasoning, affirming in most cases the positive relationship between formal educational opportunities and higher levels of moral reasoning (Duckett et al., 1992). This finding was further substantiated in work with moral reasoning in the fields of developmental and moral psychology (Beabout & Wennemann, 1994; Duckett et al., 1992; Lapsley, 1996). Therefore, the absence of relationship in this study between ethical reasoning and specific personal normative and descriptive characteristics, and in particular educational preparation, was troubling.

It became evident that the use of the EBT was the primary methodological problem. The failure of the contrasting groups technique to provide evidence supporting the claim of instrument validity cast serious doubt on the instrument's utility with this

population. Certainly a better strategy would have been to conduct validity studies prior to surveying the population of American practicing nurses in this study. It would also have been helpful to have had reported data regarding correlations between the ER portion of the EBT and the two ethical reasoning tools the EBT author used as inspiration (Dierckx de Casterle et al., 1997) for developing the EBT—the NDT and DIT.

At least four major factors could account for the differences between the results of this study and Dierckx de Casterle's work. First, despite the use of a translation expert in Dutch and English, the process of translating the instrument could have been flawed. An additional expert could have been called to provide a second translation. In addition, the changes made in the English instrument could have been sent to the author for a second reading, providing an additional check within the translation process.

Secondly, the statistically significant differences Dierckx de Casterle found in her study could be related to the large sample sizes of the technical (n = 1003) and professional (n = 1570) groups of nursing students.

Third, the process used to select the expert nurses in the Dierckx de Casterle et al. (1997) study is not clear. It is understood that the author obtained the expert nurses by "purposeful sampling through consultation of nurses in leadership positions in nursing services" (Dierckx de Casterle et al., 1997, p. 101). Being identified as an *expert nurse* might have resulted in higher scores than would have been the case without the designation. Unlike the DIT (Duckett et al., 1992), the EBT does not have built-in mechanisms to control for distortion in subject responses. Given the relatively small expert nurse sample size (n = 59), the results could be inaccurately high.

The fourth and perhaps most persuasive factor is the difference in cultural and educational influences. Belgium has a social democratic political structure. Macro and micro political decisions are made with a communitarian focus rather than the individualist approach representative of the United States' liberal democracy. As a result, ethical perspectives are likely to be different. Further, little is known about the precise nature of Kohlberg's influence in the Belgian educational system. It is possible that cognitive-developmental moral theory is inculcated early and often within the public school system. If this is true (or even if it is true within the nursing programs studied), persons taking the EBT in the Dierckx de Casterle study would be better able to identify questions related to the developmental stages and answer appropriately. Such a bias could explain the EBT's failure to provide evidence of validity in the American sample studied.

A further difficulty with the EBT that was secondary to the ER validity problem was the author's inability to provide weights from the factor analysis used to determine IMPL scores. This meant that the only scores available for analysis were ER scores. IMPL scores, and in turn ethical behavior (EB) scores could not be calculated, compromising the overall utility of the instrument.

Finally, it could be true that the ER scores are accurate and that nurses in practice score similarly to beginning baccalaureate nursing students. If, as Duckett et al. (1992) argue, levels of moral reasoning tend to increase when people engage in formal education or specific types of intervention programs, it is possible that the nurses surveyed had been exposed to little recent ethics education. This would be an important factor to include if the study were to be replicated.

Theoretical Considerations

Kohlberg's influence on understanding the cognitive-developmental nature of moral reasoning is well established. Adopting an adjusted version of Kohlberg's theory as the theoretical foundation of the EBT was a sound decision. In the case of the ethical reasoning component, it seems that the study has theoretical validity but lacks instrumentation adequate to test the theory. Regarding the character component of the research, the underpinnings of virtue ethics come from a rich background of classical philosophic thought. The philosophical and theoretical foundations of the research are integral and appropriate to the design and desired outcomes.

Limitations of the Study

The predominant limitation is the EBT's inability to discriminate between ER scores of experienced nurses and beginning nursing students. Beyond that, instruments such as the INSURE Survey™ and the EBT at best convey preferences in hypothetical situations. Though a link between attitudes, or preferences, and behaviors has been established in the literature (Fazio & Roskos-Ewoldsen, 1994), the relationship is by no means linear. The instruments in this study look indirectly at the constructs of character and ethical reasoning in hopes of providing insight into the phenomena themselves.

Further, the three variables of the INSURE Survey™—integrity, reliability, and work ethic—do not represent the whole of virtue within one's personal or professional life. These are simply examples of contemporary virtues rewarded in the workplace, and as such, cannot be generalized to imply all virtues, or that these three variables are somehow superior to others.

Implications for Research, Theory and Practice

Ethical reasoning continues to be of scholarly interest within the nursing community. However, more work is needed to fully develop research models that accurately reflect the ethical dimension of nursing practice. One of the strengths of the EBT is the relevance of its format to nursing practice. Several respondents included written comments indicating how much they enjoyed answering the dilemmas. Other nurses volunteered to be on panels to discuss ethical issues. The interest at the initial contact and in the overwhelming response rate supports the notion that direct-care nurses deeply understand the pervasive nature of ethics in their practice. They were willing to wrestle with very difficult dilemmas because similar situations are a part of their daily professional lives.

Therefore, scholarly contributions to the area of ethical reasoning and ethical behavior ought to actively include direct-care nurses at all stages of the research process. As Loewy (1997) argues, the basic issue of healthcare ethics is the character of the person, not whether or not that person comes in contact with ethical quandaries. It is time to communicate that ethics is conversation, not just problem-solving. It is in the conversation that character becomes a discussion point, and thereby a recognized and necessary component of nursing practice.

In a more concrete sense, more work is needed in instrument development, both in refinements/revisions of the EBT and in the development of nurse-specific instruments to study character, or virtue ethics, in nursing practice. Qualitative approaches will be needed to develop the foundation for instrumentation. Rigorous psychometric work

(similar to that in moral psychology) is crucial in developing instruments that adequately measure the constructs of interest.

The domain of nursing ethics for nurses in practice is vast and largely uncharted. Nurses with interests in practice-driven ethics have much to contribute to the field. Through research in new areas of nursing ethics, nursing as a discipline will develop a broader understanding of what it is to *do the good* for the patients in our care.

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Appendix A

Demographic Data Form

Please complete the following information:

Number of years in nursing practice: _____

Gender: __Male __Female

Educational preparation:

__AD in nursing __Diploma __BSN __Masters' degree (nursing)

__Masters degree (non-nursing) ___Other (specify)_____

Age: ____

Employment status:

__Full-time __ Part-time __PRN

Appendix B

NOTE TO USERS

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APPENDICES B AND C
(pages 87-114)

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APPENDICES B AND C
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Appendix D

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6911
JUN 7 '99

REQUEST FOR EXEMPTION
HEALTH SCIENCES INSTITUTIONAL REVIEW BOARD

(THIS MUST BE TYPED)

1. Name of Investigator: Nelda S. Godfrey / Susan Taylor

Investigator's Title: MN, RN, M-SCNS

Department: SCHOOL OF NURSING C194 Phone # [redacted]

(Students include home & work phone #)

Campus Address: [redacted], Liberty, MO 64068

2. Name of Project: Exploring the relationships between moral attitudes and ethical behavior in registered professional nurses

3. Brief Summary of the Project:

The purpose of the study is to examine the relationships among personal descriptive characteristics (age, years in practice, educational preparation), personal normative characteristics (moral attitudes), and ethical behavior of registered professional nurses. Nurses at three hospital sites (urban, suburban, and rural) will be randomly selected and asked to complete two survey instruments and a demographic questionnaire. Multiple regression will be used for data analysis.

4. Using the categories 1 to 5 on the back of this form, list the category of research activity that you believe applies to your research: 2

5. Briefly describe the nature of the involvement of the human subjects (personal interview, mailed questionnaire, telephone questionnaire, observation, etc.) and the reason you believe this is an exempt project:

This is research involving the use of survey procedures (item 2 on exemption statement). Subjects will be asked if they would like to participate; then hand-delivered survey instruments will be given, along with a stamped, addressed envelope for easy return.

6. Are the data recorded in such a manner that subjects can be identified by a name or code? Yes ☑ No ☑

If yes: a) Who has access to the data and how is it being stored? myself: my advisor; locked file

b) If you are using an assessment tool (e.g. the Beck Depression Inventory) what is your procedure for referring the subject for follow-up if his/her scores are significant?

N/A

c) Will the list of names and codes be destroyed at the end of the study? Yes ☑ No ☐

7. Age of subjects:

Adults (persons age 18 and older) Yes ☑ No ☐

Minors (persons under age 18) Yes ☐ No ☑

8. If your project uses a questionnaire or structured interview, attach a copy of the questionnaire or interview questions to this form.

9. Signature of Investigator: [redacted] Date: 5-17-99

TO BE COMPLETED BY THE IRB - ROOM M239 HSC. [redacted]

(Project is exempt under 45 CFR 46.101(b) (2) Date: 7-2-99

[redacted]

Authorized Signature (Health Sciences IRB)

Appendix E

July 6, 1999

Dear _____,

As a nurse, you know a great deal about ethical decision-making with patients and families. Unfortunately, nursing research is only in the beginning stages in understanding how and why nurses make the decisions they do. Your expertise as a practicing RN could be very helpful in understanding ethics in nursing practice.

I am asking for your help. Your name has been selected by random from a list of nurses at Liberty hospital.---

Would you be part of a study of **attitudes and ethical behavior of registered nurses?**

I am conducting this research as part of the requirements for my doctoral degree in nursing. The study has been approved by the hospital and has the support of nursing administration (see attached letter). The University of Missouri-Columbia Review board for Research on Human Subjects has also approved the project.

I will be contacting you at the hospital sometime within the next two weeks to talk more about the particulars. If you decide to be a part of the study, you will be asked to complete three surveys on attitudes and ethical nursing behavior.

I look forward to meeting you!

Sincerely,

Nelda S. Godfrey
Doctoral candidate, Sinclair School of Nursing
University of Missouri-Columbia

Appendix F

Script for meeting with nurses:

Hello. My name is Nelda Godfrey. You received a letter from me a few days ago asking you to participate in a research study on attitudes and ethical behavior of registered nurses. (show copy of letter if necessary)

Is now a convenient time to visit about the research? The hospital has granted me 5-10 minutes of your time to explain the research and answer any of your questions.

First of all, this is a multi-site study of work-related attitudes and ethical behavior among registered nurses. I have specifically chosen the sample from **RN's who work directly with patients** in _____hospital. Your perspective is very important to this study. The fact that you deal with ethical issues in your practice is a tremendous contribution to this research I truly want to know what YOU think.

This research is strictly voluntary, and all of your responses will be held in confidence. NO individual data will be reported during any phase of the research process. I will only know THAT you have returned the questionnaires, not what your individual responses are.. Your anonymity is assured!

Upon completing and returning the questionnaires, I will send a letter to the Vice President of Nursing, stating that you participated in nursing research and ask that the letter be placed in your personnel file. You will also receive this pin for helping.

To participate in the research, you need to do the following:

1. Answer a few questions:
   a. Do you directly care for patients?
   b. Have you been in practice more than 6 months?
2. Accept a packet of questionnaires today
3. Answer all questions, follow directions carefully
4. Return in stamped, addressed envelope enclosed
5. Return within ten days

You will need to know that the questionnaires will need to be completed BY YOURSELF and most likely during off-work time. It will take at least 45" to complete.

This is part of my dissertation research, and approved by the hospital and the Review of Human Subjects Board at the University of Missouri-Columbia.

Let me show you how the questionnaires work:

1. demographic form
2. attitude survey—answer with your best choice. Answer all items
3. Ethical behavior test—five dilemmas, read carefully, answer all items. The format is the same for all five dilemmas, so be patient with yourself as you do the first one, and you'll have the hang of it soon!

Will you help with this research project?

Do you have any questions?

Appendix G

July 8, 1999

Dear Colleague,

Thank you for being a part of this research project! This study is the first of its kind to assess the relationships between work-related attitudes and ethical behavior of registered nurses in urban, suburban, and rural settings. Your input as a practicing RN is invaluable—THANK YOU for your effort.

Please be assured that your responses will be held *confidentially*, and that your participation is *voluntary*. Your hospital will receive composite data representing all respondents from that institution. No one will know of your individual responses.

With that in mind, let me ask that you follow these guidelines:

1. Read the instructions very carefully, and follow the directions.

2. **Please answer every question.**

3. Do not ask others for their opinion. It is your opinion that is requested! Complete all questionnaires without assistance from others.

4. Please answer with your personal opinion. Do not try to think what others might do or what the researcher might want.

5. **This project takes time!** Please allow at least 45" to complete the set of questionnaires.

This research is part of the requirements for a doctorate in nursing from the Sinclair School of Nursing, University of Missouri-Columbia. Should you have any questions about the research, please call me at [redacted] The project has been approved by the University of Missouri Health Sciences Review Board for Human Subject Research. If you have concerns about human subject protection, I direct you to Dr. Susan Taylor at [redacted]

Finally, you may request the report of the findings by completing the postcard enclosed in the packet. I will be happy to send you a copy of the results.

Your insights and responses are very valuable! Thank you for being willing to share your thoughts on such important topics.

Sincerely,

Nelda Godfrey PhD (C), RN, M-SCNS
Doctoral candidate
Sinclair School of Nursing
University of Missouri-Columbia
[redacted]
Liberty, Missouri 64068
Phone: [redacted]

VITA

Nelda Schwinke Godfrey was born [redacted], in Carrollton, Missouri, and moved to the family farm near Morrison, Missouri, at age five. After attending public schools, she received the following degrees: B. S. in Nursing from the University of Missouri-Columbia (1977); Master of Nursing from the University of Kansas (1980); Ph.D. in Nursing from the University of Missouri-Columbia (1999). She is married to Darrell Godfrey of Henderson, Iowa, and is presently a member of the Nursing Department at William Jewell College, Liberty, Missouri. [redacted]

[redacted]