# MORAL DECISION MAKING BY NEONATAL INTENSIVE CARE NURSES

by

PAMELA CHALLY

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the
Degree of Doctor of Philosophy in Nursing
in the School of Nursing in the
College of Health Sciences
Georgia State University

Atlanta, Georgia

1990

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ABSTRACT
MORAL DECISION MAKING BY NEONATAL INTENSIVE CARE NURSES
by
PAMELA S. CHALLY

PURPOSE

The purpose of this research was to gain information about the perspective neonatal intensive care nurses use to make moral decisions. Previous research in nursing has assumed acceptance of Kohlberg's theoretical conception of moral development. This research incorporated more recent development theory to include not only a Kohlbergian justice perspective, but also, the care perspective described by Gilligan.

Research questions included:

1) To what extent is a care perspective used by registered nurses as they make moral decisions?
2) To what extent is a justice perspective used by registered nurses as they make moral decisions?
3) To what extent do registered nurses combine the justice and care perspective as they make moral decisions?
4) Can any additional perspectives be identified that do not clearly fit into the care or justice perspective?
5) How do demographic variables relate to the perspectives used by registered nurses to make moral decisions?

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## METHODS

Experienced neonatal intensive care nurses were interviewed concerning moral dilemmas they had experienced. Subjects were also asked to complete a demographic questionnaire. Descriptive analysis was used to analyze the data as well as interpretive analysis. Interpretive analysis sought to understand how nurses make moral decisions by listening for specific approaches in the audiotaped interviews.

## RESULTS

The results of this study indicated that nurses use more than one perspective as they make moral decisions. The predominant number of nurses used a perspective of care (65%). A small number used a justice perspective (12%), and the remaining nurses (23%) used a combined care/justice perspective. No additional perspectives were identified. Nurses who were younger in age, and who had fewer years of neonatal intensive care experience were less likely to practice from a care perspective.

A taxonomy of care and justice was identified. Nurses resolved moral issues from Gilligan's second and third levels. Evidence also validated that nurses deliberated from Kohlberg's third, fourth, and fifth stages.

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## CONCLUSIONS

The researcher concluded that nurses were concerned with care and justice. Both perspectives are important to understanding the true voice of our profession.

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Chally, P. S. (1990). Theory derivation in moral development. Nursing and Health Care, 11(6), 302-206.

Chally, P. S. (1990). Moral and ethical development research in nursing education. Annual Review of Nursing Education Research, 3, 33-47.

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ACKNOWLEDGMENTS

I wish to express my gratitude and deep appreciation to the many people that have made this dissertation a reality. Reaching a goal is never the work of just one person.

I want to thank my committee members. Dr. Tommie Nelms, who chaired my committee, encouraged and gave of herself. She has become a role model for my endeavors in nursing education. Dr. William Bechtel introduced me to new ways of viewing the world. There is more than perspective. Dr. Charlotte Warren was willing to spur me on at the end and allow this dream to become a reality. I also am indebted to Dr. Kathryn Chance, who because of illness was no longer able to chair my dissertation committee. She was the original source of inspiration, who encouraged my ideas and creativity in the area of moral development.

I wish to express my appreciation to my family. Rod, my husband, always encouraged me to be me, and provided the extra energy I needed to achieve this dream. Jennifer and Jonathan were with me through out this endeavor, sensing when mom needed a kind word or a hug. I thank you all.

This research was supported in part by a NAACOG: The Organization for Obstetric, Gynecologic and Neonatal Nurses Grant.



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# CHAPTER I

## INTRODUCTION

As society has changed, the health care professions have developed and changed to meet new needs. Nursing, as one of the professions, has expanded its scope of practice as a result of scientific and technologic advances, extended life expectancy, and changing lifestyles. Nurses are assuming increasing responsibility for making independent judgments in a variety of health care settings. This includes the need to make moral decisions concerning a myriad of dilemmas which impact practice.

Ethics involves the examination of moral dimensions in nursing practice. It is the study of what actions and conduct should be in reference to ourselves, other human beings, and the environment. Ethical nursing practice is "based on and includes critical, reflective thinking about one's duties and obligations as an individual nurse in relation to clients and as a member of a profession fulfilling a social contract" (Aroskar, 1982, p. 22).

The profession of nursing espouses ethical practice as very important in the delivery of health care. The Code for Nurses (American Nurses' Association, 1976) mandates ethical practice. The preamble states that, "The statements of the Code and their interpretation provide guidance for conduct and relationships in carrying out nursing responsibilities consistent



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with ethical obligations of the profession and quality in nursing care" (p. 45). Unfortunately, it is not always clear what solution is in the best interest of the patient and/or the profession. Nurses may be forced to choose between patient interest and the interest of others. Should a patient's death be hastened because the family is so emotionally and financially drained? A decision may need to be made between moral integrity and professional survival. Should the nurse be dishonest in order to cover up a disastrous mistake by the physician? Aroskar (1982) states that ethical practice is risky and may actually require heroism on the part of the nurse.

Examples of moral decisions made by nurses in all practice settings are abundant. Davis (1981) validates that nurses have a good grasp of the concept of ethical dilemmas. In her study the nurses were able to give numerous examples from their clinical experiences. The most frequently occurring dilemmas included prolonging life with so-called heroic measures and unethical or incompetent activity of colleagues.

Neonatal intensive care unit (NICU) nurses, like all nurses, experience moral dilemmas on a day to day basis. Because of the exploding technology in this area, however, these professionals may face even more ethical concerns than many of their nurse counterparts. For example, when is a baby "too" premature to be subjected to treatment? If it becomes clear that the infant is

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not benefiting from aggressive therapy, can the goal of care be redirected from cure to comfort? What about the infant's life after discharge from the intensive care unit? A child may be so severely handicapped that we rightfully question if life is really in the neonate's best interest. Penticuff (1987) described the suffering of infants in NICU as they undergo painful procedures without the benefit of anesthesia or even any comfort measures such as rocking and holding. How do nurses reconcile the tenet of "do no harm" with the reality of this situation?

The following case study cited by Veatch and Fry (1987) is an example of use of heroic measures to save a very famous baby known as Baby Fae. It also delineates moral dilemmas experienced by a neonatal nurse.

> Marie Whisman, a neonatal nurse-specialist, once cared for a very special baby. This baby, known to the public as Baby Fae, was born on October 14, 1984, with hypoplastic left heart syndrome, a normally fatal cardiac abnormality. The recommended treatment was a heart transplant. Since a human heart was not believed available for Baby Fae, her physicians considered performing an [sic] xenograft--a procedure replacing her heart with that of a baboon. The procedure was explained to her parents, their consent was obtained, and the surgery was performed on October 26, 1984. Baby Fae survived

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for 21 days but died of complications from rejection of the xenograft.

Marie Whisman was Baby Fae's primary nurse. At the infant's funeral, Ms. Whisman read a statement about the nursing care that this special infant received. Unstated, however, were many questions about the role that nurses play in the care of patients undergoing innovative therapies that can also be described as research. Of what benefit to Baby Fae was this particular procedure? What obligation did Ms. Whisman have to Baby's Fae's parents to inform them of the special risks and limited benefits of the planned procedure? Was the planned procedure of such great benefit to society that the risk to Baby Fae's life was justified? How does a nurse caring for a patient assess the risks and benefits of innovative procedures and decide whether or not he or she wants to continue to participate in care involving innovative treatment? Ms. Whisman was the human being who touched and cared most for Baby Fae during her short life and was a participant in every procedure that was performed on the infant. What obligations does a nurse have in this situation to the infant? To the parents? To the research team? (p. 237)

Additional ethical questions nurses working in perinatal nursing must deal with include: Should a pregnancy be terminated

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when the risk of congenital malformation is high? Should parents be informed of abortions agreed to by teenagers? Is it ever appropriate to undergo an abortion when the baby is the undesired sex? At how many weeks gestation should one not attempt to save a premature neonate? How vigorously should a baby be treated when tests indicate severe brain damage? Should a woman be forced to undergo a procedure she is strongly opposed to if it is in the fetus' best interest?

## Statement of the Problem

A theory of ethical practice is essential to the maturation of nursing as a profession (Huggins & Scalzi, 1988), but in order to be useful the theory must be based on nursing's true experience with moral decision making. Most previous nurse researchers, as described in the review of the literature section, have conceptually based their studies on Kohlberg's (1971, 1973, 1976, 1978) theory of moral development. Although very useful in early studies, it is apparent now that Kohlberg's work is not inclusive of the total experience of all people. The theory development done by Kohlberg, describes a male perspective that is not necessarily comprehensive or based on actual actions of subjects in real world situations. It is called a justice perspective. (See section on theoretical framework for further discussion and documentation.)

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Gilligan, as a student and colleague of Kohlberg, was aware of limitations in Kohlberg's particular account of moral development. Her earliest work (1977, 1982) began by including the experiences of women. This was a very important step, but the sample she studied was certainly not representative of the norm of female moral decision making. Twenty-nine women who were referred by abortion and pregnancy counseling services made up Gilligan's initial sample of subjects from which she described, "in a different voice," women's experiences with moral development. Subsequent studies have included a more representative sample of females and males. For example, the study reported in 1982 by Gilligan, Langdale and Lyons was based on a cross-sectional sample of thirty-six individuals evenly divided by sex at each of nine ages from 8 years to 60+ years. Gilligan and Attanucci (1988) analyzed moral conflicts in 80 educationally advantaged males and females. Yet, even Gilligan is very careful to report that her theory may not represent all people's experiences. It represents what she and her colleagues have determined to be accurate from their pool of subjects. Gilligan's model has been identified as care perspective.

At first glance, Gilligan's (1982, 1987) moral development theory seems to be a good fit for nursing as a method of describing or explaining moral behavior. She describes a perspective of care that is certainly in keeping with nursing's

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historical and philosophical traditions (Cooper, 1989). Also it is most important that a profession primarily of women include a feminine perspective in any theory development. Yet, it is the concern of this researcher that nursing not jump on a new band wagon that is not appropriate for the profession. Nurses' experiences with moral decision making, although basically feminine because of the predominance of women in the profession, may or may not be like subjects Gilligan and her colleagues have studied due to their professional experiences and education. It is significant to note that moral decision making in a professional setting has not been studied by Gilligan and her colleagues.

This study was concerned with whether the perspective of care, identified originally by Gilligan, was in keeping with nurses' professional experiences or if Kohlberg's justice perspective was more commonly used. In addition, the researcher was interested in whether nurses combined the two perspectives or if a new perspective could be identified.

It is important to identify clearly what this study's purpose was not. The researcher was not intending to address or solve the normative question of ethics. The focus of this study was to gain further knowledge about how nurses are presently making moral decisions. It was an attempt to understand the perspectives involved in ethical decision making. Nurses were

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asked to reflect on what they believed affected their action when they confronted an ethical dilemma. The focus was not on evaluative judgments; neither was the study's goal to identify moral obligations, duties or values that should guide nurses' moral actions. It is acknowledged that the thought process about what happened when making a moral decision is very different from what decision is the best.

## Theoretical Framework

The theoretical framwork for this research was developed by thoroughly studying Kohlberg's (1971, 1973, 1976, 1978) & Gilligan's (1982, 1987) moral development theories. It was decided to build upon Gilligan's and her associates' recent work (Brown, 1988; Gilligan, 1987; Gilligan & Attanucci, 1988; Gilligan, Brown & Rogers, 1988) which differentiates between a perspective of care and a perspective of justice as moral dilemmas are deliberated.

Kohlberg was a very prolific moral development theorist whom nurses frequently cite as a basis for their conceptual frameworks when implementing moral development research. Ketefian, (1981a, 1981b, 1982, 1985, 1987) a well respected nurse researcher, in particular built upon Kohlberg's work. (A review of her research is included in the review of the literature section.) The author reviewed developmental theorists that Kohlberg frequently credits as influencing his thinking. These include Dewey and Piaget.

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Dewey (1916) was an influential philosopher and educator who advocated a cognitive developmental approach to moral education in the secular school settings. His approach was cognitive because it recognized that moral education stimulates the active thinking of the child about moral dilemmas. It was also developmental because the educative process proceeded through moral stages. Dewey theoretically postulated three levels of moral development: a) the pre-moral or preconventional level of behavior which motivates morals by biological and social impulse, b) the conventional level of behavior when individuals accept the standards of their reference group without much reflection, and c) the autonomous level of behavior where individual thinking and judgment guide conduct, rather than the standard of one's reference group.

Piaget (1965) observed the development of moral judgment in children from preschool through middle school years. He focused his observations of moral judgment on children as they played games of marbles and resolved dilemmas arising from the violation of the elaborate system of socially accepted rules of the game. Three distinct developmental stages of morality were identified: a) the pre-moral stage which is characterized as no sense of obligation to rules (younger than 4 years), b) the heteronomous stage in which the "right" is absolute obedience to rules along with a submission to punishment and power (approximately 4-8

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years), and c) the autonomous stage described as when the consequence of following rules is based on reciprocity and exchange (approximately 8-12 years).

## Lawrence Kohlberg

Kohlberg (1978) further defined the Dewey-Piaget levels and stages through the following validating studies: a) fifty Chicago-area boys from middle and working class, interviewed at ages 10-16 initially and re-interviewed at three year intervals for twenty years, b) a small number of Turkish village and city boys interviewed longitudinally over a six year period, c) a variety of other cross-sectional studies in Canada, Great Britain, Israel, Taiwan, Yucatan, Honduras, and India. Subjects interviewed were asked to respond to hypothetical, open-ended moral dilemmas. Responses were interpreted according to a defined set of scoring procedures.

Based on his research, Kohlberg (1978) postulated three levels of moral development: preconventional, conventional, and postconventional. Each level is further subdivided into two stages. Progression through the stages occurs over varying lengths of time, but each stage is sequential and is characterized by higher capacity for logical reasoning than the preceding stage. The theory equates moral development with development of reasoning based on justice.

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The best known of Kohlberg's cases, Heinz' dilemma, clearly illustrates this developmental approach. Heinz' wife is dying of a disease which can solely be cured by a drug that a pharmacist in town has access to. The pharmacist is only willing to sell the medication at an exorbitant and unfair price that Heinz cannot afford. Heinz has no way to obtain the needed drug, so he steals it. Subjects are asked if Heinz should have stolen the drug. A summary of Kohlberg's levels and stages will be presented along with Morrill's (1980) proposed responses to Heinz' dilemma.

Preconventional Morality. Individuals at this level do not consciously attend to the norms of society when responding to moral problems. One's perspective is egocentric. This is the level of most children under nine as well as some adolescents and adult criminal offenders.

Human beings operating in stage one, referred to as heteronomous morality, have a punishment-obedience orientation. It is right to avoid breaking rules in order to prevent punishment. "Right" is dependent upon another's ability or force. Children would expect Heinz to be caught by the police and punished. Since Heinz was punished the act would be wrong.

The second stage is termed instrumental morality. The orientation is toward more concrete ideas of direct and immediate reciprocation or retaliation. One's own needs or interests are

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the basis for decisions. Rules are followed only when this is in one's immediate interest or involves an exchange or deal. Persons in this stage recognize that others have the same need to promote their own interests. Children in stage two would view stealing as wrong because of the personal sacrifice of imprisonment and removal of Heinz from family and friends.

Conventional Morality. This is the level at which most adolescents and adults function in our society. Maintaining expectations of one's family, group, or nation is valued. Loyalty to existing social order is also considered important.

The third stage is referred to as mutual morality. "Right" is living up to what is generally expected of people in a certain role. Social approval is the prized reward. The person attempts to meet expectations of "good" behavior by showing concern for others and having good motives. People one personally interacts with are more important than unknown individuals. Pain or punishment may be endured to fulfill the expectations of the stereotype. Persons functioning at this level would feel Heinz was justified in stealing the drug if he received praise from friends and neighbors for having done so. He would not be justified in stealing the drug at stage three if he received a negative response from others.

Stage four, named social system morality, is characterized by many of the same elements as stage three. The difference

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between stages three and four lies in the object of conformity. Stage three involves conformity to persons, whereas stage four is dominated by conformity to rules including legal, organizational, and professional laws. "Wrong" action is defined as the violation of the rules, regardless of the consequences or irrespective of the reasonableness of the rule. People in this stage would disapprove of theft since laws prohibit such behavior.

Postconventional Development. The final level of development involves more internal and independent modes of thinking than previous stages. The individual autonomously examines and defines moral values. The stage is reached by a minority of adults, usually only after age 20.

In stage five, entitled social contract morality, a person recognizes the existence of mutually exclusive, yet competing rights and values within the moral domain. The individual views the law as binding, but also recognizes it can be changed for rational considerations of social utility. Concepts such as duty, greatest good for the greatest number, human rights and democracy become meaningful. Regarding Heinz, acute conflict between legal and moral responsibilities would be felt. Individuals at this level may opt to side with the law in terms of wrongness of the theft.

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Stage six is entitled universal ethical morality. It is demonstrated by the application of universal ethical principles that are self-chosen, logical, comprehensive, and universal to moral dilemmas. The principles develop from the person's philosophy of life. Stage six intends a higher degree of abstraction than previous stages. In situations of conflict, principles can supersede the demands of law or social agreements. In Heinz' dilemma the universal principles of justice and fairness grounded in the individual's conscience value life over property. Theft of the drug would therefore be justified. This stage is rarely, if ever, consistently identified as an approach to moral reasoning, but is morally and developmentally superior to preceding stages.

Kohlberg (1971, 1976) purports that certain conditions may stimulate higher levels of moral development. Intellectual development is one necessary characteristic. Individuals at the level of formal operations are more advanced in moral development than those operating at the level of concrete operations. An environment which offers opportunities for group participation, shared decision-making processes, and responsibility for the consequences of actions also promotes higher levels of moral reasoning. Further development is stimulated by the creation of conflict or disequilbrium in settings where the individual recognizes the limitations of present modes of thinking.

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Motivation develops to construct new modes of thinking that more adequately deal with the presented dilemmas. Students have been stimulated to higher levels of conventional and post conventional reasoning through participation in courses on moral discussion and ethics (Kohlberg, 1973). Such an expansion in perspective allows the individual to make moral judgments free from individual and social needs from which morality had earlier been defined, but instead based on the universal applicability of the principle of justice.

Kohlberg is the most prominent name in moral education today. It is hard to imagine a discussion of moral education without referring to Kohlberg's work. His ideas are unusually bold in their scope and claim of universality. He bravely concluded that there was a universal and normative structure of moral good that can be identified and developed. Although it is not the intention of this paper to thoroughly critique Kohlberg, it is important to note the controversial nature of his work. Peters (1976) agreed that what there is of Kohlberg is excellent. He wrote well and was prolific. His influence is not limited to specific disciplinary boundaries. It is debated in psychology, philosophy, education, sociology, and nursing circles.

Unfortunately, his work creates special problems for nursing when it is extolled as the method in which individuals morally

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develop. Briefly stated objections to the use of Kohlberg's theory in nursing include:

1) Actual actions of subjects in the real world were not studied. Subjects were presented with hypothetical dilemmas and then asked to respond. Can it be presumed that what a person says will be done in a hypothetical situation will actually be done?

2) The comprehensiveness of Kohlberg's underlying conception of morality can be questioned. Subjects were presented with a limited type of moral dilemmas having to do with justice and fairness in terms of competition, property rights, right to life and obligations (Flanagan, 1984). The dilemmas were all very specific and constitute only a portion of the set of ethical issues human beings confront. Can a universal model be claimed based on research on a portion of identified moral principles?

3) The final objection is the issue of sex bias. Kohlberg's theory is originally based on a study of 50 males, but assumes that as all individuals (males and females) develop, moral dilemmas are interpreted according to his six distinctive stage constructs. Women are generally "stuck" in the third or fourth stage where moral behavior is based on the establishment of mutually helpful relationships within social groups (Gilligan, 1977). Men, however, more frequently progress to higher levels

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of moral thinking which are characterized by the maintenance of social order, justice and universal moral principles. Sampling bias can thus produce a narrow picture of moral development.

Based on these objections, nursing must go beyond embracing only Kohlberg's theory of moral development and incorporate more recent theory in moral development addressing the objections raised. Gilligan's work offers a perspective that eliminates objections raised to Kohlberg's theory.

## Carol Gilligan

Gilligan (1977, 1982) was particularly concerned that Kohlberg did not give adequate acknowledgment to the concerns and experience of women in moral development. She recognized that he had largely generated theories of development based on research with men. The issue of women plagued his findings. Women's identity is tenaciously dependent on relationships with others. Because of this contingency on others, women were considered deviant or developmentally deficient in Kohlberg's theory (Gilligan, 1977).

Twenty nine women diverse in age, race, and socioeconomic status participated in Gilligan's (1977) research designed to clarify the nature of women's moral judgment as they faced the real moral dilemma of whether to continue or abort a pregnancy. The women were referred by abortion and pregnancy counseling services. They were asked to discuss the decision that

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confronted them about the abortion, i.e., how they were dealing with it, alternatives being considered, people involved, conflicts implicated and ways in which making the decision affected their self-identity and relationships with others. In the second part of the interview, moral judgment was evaluated using three of Kohlberg's research dilemmas.

Results indicated that progression in moral development from a preconventional to conventional to postconventional level could clearly be discerned. Yet Gilligan (1977) reported that women's moral judgments differ from men's. For women the moral problem was defined in the context of exercising care and avoiding hurt. The infliction of hurt was viewed as selfish and immoral; the expression of care was viewed as the fulfillment of moral responsibilities. The use of words referring to selfishness and care and the underlying moral orientation reflected by such language was not addressed by the men in the Kohlberg (1978) studies.

The following developmental sequence was described by Gilligan (1977):

The First Level: Orientation to Survival. Women's moral judgments initially center on self. The woman focuses on caring for herself as a matter of survival. She feels alone. An example from Gilligan's interview data with a pregnant woman considering an abortion illustrates this.

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> Susan, an eighteen-year-old, asked what she thought when she found herself pregnant, replies: 'I really didn't think anything except that I didn't want it. [Why was that?]
>
> I didn't want it, I wasn't ready for it, and next year will be my last year and I want to go to school ... [Is there a right decision?]
>
> There is no right decision. [Why?] I didn't want it' (pp. 492-493).

Transition: Selfishness to Responsibility. The words selfishness and responsibility are frequently heard in the transition which follows the first level of judgment. Self is referenced as a redefinition of the self-interest which has thus far served as the only basis for moral judgment. Responsibility is seen as growing from connection to others. The wish to do something for oneself may remain but decision making affirms issues of responsibility and care. The transition signals an increase in self esteem since the conception of self must include the possibility of doing the right thing.

The Second Level: Goodness as Self Sacrifice. The second level, goodness as self-sacrifice, results in the emergence of the traditional feminine voice. Worth is based on the ability to care for and protect others. The world constructed by these women is perfused with assumptions defining feminine goodness as tact, gentleness, sensitivity, and self sacrifice. Gilligan

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(1977) suggests "the strength of this position lies in its capacity for caring; its limitation is the restriction it imposes on direct expression" (p. 496). The following example by Gilligan (1982) illustrates this point. Judy, a nineteen-year-old, is contrasting her reluctance to criticize with the straight-forwardness demonstrated by her boyfriend:

> I never want to hurt anyone, and I tell them in a very nice way, and I have respect for their own opinions, and they can do things the way that they want. He usually tells people right off the bat. He does a lot of things out in public which I do in private. It is better, but I just could never do it (p. 80).

Transition: Goodness to Truth. During the second transition, from goodness to truth, the woman begins to scrutinize self-sacrificing goodness under the guise of a morality of care. One begins to wonder whether it is moral or immoral to include one's own personal needs within the context of responsibility. The woman struggles to determine if acting morally is functioning according to what is best for self or if self-sacrificing for others is necessary. During the first transition from selfishness to responsibility, the woman may need prodding to remember the needs of others. Now the needs of self must be deliberately exposed. Thus she attempts to meet the

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needs of both self and others. To be responsible to others is to be good; to be responsible to self is to be honest and real.

The Third Level: The Morality of Nonviolence. The problems in the inherent transition from goodness to truth give rise to the third level, the morality of nonviolence or the injunction against hurting. At this level, which Gilligan (1982, 1987) in more recent writing calls the care perspective, the woman recognizes moral equality between self and others. "Care then becomes a universal injunction, a self-chosen ethic" (Gilligan, 1982, p. 90) that allows the assumption of responsibility for choice.

Gilligan's (1982) description of Sarah, a 25-year-old who is functioning at this level, indicates that Sarah recognizes the traditional definition of feminine virtues is getting her nowhere. Aligned with this recognition is acknowledgment of her own individual worth. Sarah says:

> I am suddenly beginning to realize the things that I like to do, the things I am interested in, and the things that I believe and the kind of person I am is not so bad that I have to constantly be sitting on the shelf and letting it gather dust. I am a lot more worthwhile than what my past actions have led other people to believe (p. 93). Responsibility for care includes both self and others with an obligation not to hurt. This

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responsibility reconstructs into a universal guide for moral choice.

Gilligan's (1977, 1982) abortion study then suggests that women comprehend moral dilemmas in terms of conflicting responsibilities. The sequence includes three levels and two transitions, with each level representing a more complex understanding of the relationship of self and others and each transition resulting in a crucial reevaluation of the conflict between selfishness and responsibility. Women's moral judgment proceeds from initial concern with survival, to a focus on goodness, to a principled understanding of care. The moral person is understood as one who responds to need and demonstrates a consideration of care and responsibilities in relationships.

Gilligan (1982) in her book, In a Different Voice, identified and described a moral development perspective focused on care. This perspective differed from the orientation toward justice as described by the all-male sample in Kohlberg's studies (1973, 1976, 1978). Previously the care perspective voiced by women in Gilligan's studies has been all but completely obscured. Recent work by Gilligan and her associates has attempted to define the relationship between the two moral orientations.

Gilligan and Attanucci (1988) determined that both the perspective of care and justice were present when people faced real-life moral dilemmas, but people tend to focus on one set of

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concerns and only minimally present the other perspective. As expected, the care focus was more often exhibited by women and the justice focus was more often exemplified by men. Ways that the justice and care perspective simulate different dimensions of human relationships giving rise to moral concern were discussed. A justice perspective is more concerned with issues of inequality and oppression and strongly values the ideal of reciprocal rights and equal respect for individuals. A care perspective is more concerned with issues of detachment or abandonment and strongly values the ideal of attention and response to need.

The justice and care perspective in themselves, are not hierarchially ranked but designated as two separate moral perspectives that organize thinking in different ways. The justice perspective strives to treat others fairly while the care perspective endeavors not to turn away from someone in need. Tension is suggested between these two perspectives by the fact that detachment, which is the hallmark of mature moral judgment in the justice perspective, becomes the moral problem in the care perspective, i.e., failure to meet needs. Conversely, attention to individual needs and circumstances, the hallmark of mature moral judgment in the care perspective, becomes the moral problem in the justice perspective, i.e., failure to treat others fairly and as equals (Gilligan & Attanucci, 1988). It is therefore easy

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to understand why women's responses based on a care ethic have been misevaluated under Kohlberg's justice ethic.

Huggins and Scalzi (1988) suggested that nursing has selected a Kohlbergian theory base that reflects a male bias and is unable to "speak to the true voice and experience of nursing" (p. 44). Although most practicing nurses are women, our patients are equally divided between males and females. How unfortunate it would be to eliminate either perspective, as we strive to understand moral development. Can it be said that nurses are not concerned with justice? Certainly nurses are concerned with caring, the essence of the profession (Watson, 1985). The mature moral development of all human beings must be supported no matter what their gender or ethical perspective.

Gilligan and Attanucci (1988) have supported that individuals focus their attention on either the care or justice perspective and that one's orientation is gender related. Yet it seems very likely that many individuals would raise concerns of both care and justice. Gilligan (1987) reported that a care/justice group would be of particular interest. At one time care might prevail as a moral orientation, but in other circumstances the justice orientation may be obvious. An example might be a male physician who firmly holds to the rule of never abetting euthanasia, even though patients and family attempt to strongly influence him. This physician continues with heroic

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measures way beyond the time when any hope remains. His elderly mother then suffers a massive stroke. She lays for six weeks unconscious, but very restless as if in pain. There are no signs of progress. He decides no feeding tube will be inserted and requests a "do not resuscitate" order. When discussing his decision to allow his mother to die with dignity and in peace, he relates his desire to sit with his mother and make her final days as comfortable as possible.

Brown (1988), who studied and works with Gilligan at the Center for the Study of Gender, Education, and Human Development at Harvard University, further described the two moral voices that have been identified. She reported that people represent both voices in their discussions of moral conflict, although often a preference for one over the other is indicated. In addition it is assumed the person may actively chose one voice over the other in any given situation. The two moral perspectives are not conceived as dichotomous or opposite but rather as different orientations to a moral problem that may or may not change over time.

Metaphorically this approach to understanding moral conflict was described by Brown (1988) as interpreting through a different lens. Each lens brings the dilemma into a different focus. Depending on which lens is used, details of the narrative may focus differently. This visual technique attunes the reader to

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specific language of the narrator while maintaining the integrity of the whole story. Reading through one interpretive lens and then the next, the reader sees ways in which a situation can be viewed from more than one angle.

Gilligan, Brown, and Rogers (1988) have described this complex combined care/justice perspective of moral development as a musical fugue. The Random House Dictionary of the English Language (Flexner, 1987) defines fugue as "a polyphonic composition based upon one, two, or more themes, which are enunciated by the several voices or parts in turn, subjected to contrapuntal treatment, and gradually built up into a complex form having somewhat distinct divisions or stages of development and a marked climax at the end" (p. 773). This musical metaphor is sensitive to the many perspectives of moral development. The fugue suggests a way to listen to various voices and variations on the voices. The plain song of care and its themes of connection may be heard at times with great clarity. In other circumstances the plain song of justice and its melody of rights may be loudest. In addition both themes of justice and care may be harmonized to make a whole.

## Concluding Ideas

Moral development theory according to Kohlberg (1971, 1973, 1978) is based on the idea that postconventional decisions are morally better than conventional decisions, which in turn are

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better than preconventional decisions. How do we know this is the case? Kohlberg has not made connections showing that one level of moral development inconclusively builds on the next except as the stages relate to Piaget's (1965) description of cognitive development. It is possible that living up to the expectations of various social groups (i.e., conventional level) is more moral than independently and autonomously defining moral values (i.e., postconventional level). Let us refer to an example from the Vietnam era. Was living up to the United States government's expectation that young men would fight or nurses would care for the wounded (conventional level) really better than protesting America's involvement in Southeast Asia on grounds of protecting the rights of Vietnamese citizens (postconventional level)? The answer is difficult to determine.

The intention of moral education is to stimulate the next step of development. Are we certain that stimulating the next step of development is in the child's best interest? Again, such is based on the assumption that a person in whom the self is identified with internalized rules of others is not as morally mature as one who has differentiated self from rules and expectations of others and defines values in terms of self chosen principles. Could we function in a world where everyone was morally developed to the level of Abraham Lincoln or Martin

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Luther King, men Kohlberg has determined functioned at stages 5 and 6?

Gilligan's (1977, 1982) description of moral development could be scrutinized similarly, although she does attempt to make connections particularly during the transition phases. Is the morality of nonviolence, when moral equality between self and others is recognized, necessarily better than self sacrificing for others? Consider the following scenario: An uneducated, widowed, immigrant mother comes to the United States with her children. The women works tremendously long hours in miserable factory conditions in order to provide for her children's physical needs and education. The eldest daughter becomes a nurse and contributes significantly to our understanding of nursing care of patients' experiencing pain. What if the mother had felt no need to sacrifice for her children? Consider how many people have benefited from that selfless offering.

Other concerns about use of Kohlberg's (1971, 1973, 1978) moral development theory in nursing have been addressed by Gilligan (1982, 1987). She does study subjects in the real world and males and females both make up her sample. In addition the underlying conception of her morality is broader since ethical dilemmas studied come from subjects experiences in all circumstances of life. Yet, care in relationships that Gilligan

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discusses centers on personal connections. How might this change once professional relationships are explored?

Kohlberg describes justice as the only important moral approach. He boldly proclaims that justice decisions are those on "which all moral men could agree" (Kohlberg, 1978, p. 41). Gilligan points to the existence of two distinct moral voices, care and justice. Why not more? Penticuff (personal communication, September 1, 1989), a perinatal nurse researcher, has declined to use moral development as a theoretical framework in her research partly because it does not seem to be comprehensive enough to include nurses in a health care setting. Organizational characteristics relevant to the resolution of ethical dilemmas such as administrative support, communication between health team members and nursing staff resources (Penticuff, 1989) are difficult to box into the two perspectives of care and justice. It may be that additional perspectives have yet to be described.

This researcher does not view moral development as the panacea for all nursing ethical decisions. Instead she acknowledges the contribution the theory has made in describing a developmental process of moral reasoning. It must be recognized as only one way of approaching nursing ethics that has been used to justify conceptually a number of empirical research studies interpreting nurses' moral behavior, judgment, and reasoning.

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This study will use moral development, described recently by Gilligan (1987) and Gilligan and Attanuci (1988) as a theoretical framework to further delineate how nurses make moral decisions.

## Statement of Purpose

The purpose of this research study is to gain information about the perspective neonatal intensive care nurses use to make moral decisions. Previous research in nursing has assumed acceptance of Kohlberg's (1971, 1973, 1976, 1978) theoretical conception of moral development developed from longitudinal research with males. Use of Kohlberg's model has significant implications for nursing as discussed in the theoretical framework section. This descriptive research will incorporate recent moral development theory and methodology to include not only a Kohlbergian justice perspective, but in addition, the care perspective described by Gilligan (1982, 1987). From analysis of the data, the researcher hopes to identify the perspective nurses use to make moral decisions. It is recognized that a perspective combining both care and justice may be identified or that a different perspective may emerge.

## Assumptions

Assumptions of this study include:

1) Nurses are confronted with moral dilemmas.
2) Nurses singularly or in collaboration make decisions about moral dilemmas.

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3) Nurses are able to report incidents of moral decision making.

4) Moral decision making is dependent on moral development.

5) The interviewer, a professional nurse, is able to understand the interviewed nurse's story because of common experiences and a common language.

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## CHAPTER II

## REVIEW OF LITERATURE

A review of literature in the field of nursing ethics and moral development was done. Literature from these areas that supports the purpose of this study is discussed. Areas reviewed include: nursing education research on moral development, moral development and additional variables, non-Kohlbergian conceptually based studies, unethical behaviors of nursing students and faculty, and qualitative studies.

### Nursing Education Research on Moral Development

Most published research concerning nursing ethics deals with moral development and identifies nursing education as a key variable. All of the studies discussed are theoretically based on Kohlberg. The review presented in this section discusses nursing education research on moral development according to the following categories: research tools used, the effect of specific ethics content/course on moral reasoning and judgment, and educational level's relationship to moral development.

#### Research Tools

The largest majority of studies identified were conceptually based on Kohlberg's model of moral development. Two commonly used tools in such studies, derived from Kohlberg's theory, are the Defining Issues Test (DIT) developed by Rest (1979) and Ketefian's Judgments about Nursing Decisions (JAND) (1982).



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Pertinent findings in cited studies will be addressed in sections on ethical content/course and educational level.

Rest's DIT (1979) is a multiple choice test which includes six descriptions of individual's facing a moral dilemma. The person completing the test selects statements that are believed to be important in making a decision about the dilemma. Each statement choice characterizes one of Kohlberg's stages or is a distractor or antiestablishment item. There are many ways of summarizing and rating the data (Rest, 1979). The D score indicates the individual's preference for principled thinking (Kohlberg's stages 5 and 6) over conventional and preconventional reasoning (Kohlberg's stages 1-4). It is calculated from all stage scores and and is expounded as an overall standard of moral judgment. The P score reflects the importance a subject gives to morally principled considerations in making moral judgments. This score indicates moral reasoning ability at the principled level and is calculated by adding the scores for stages 5 and 6 only. Schlaefli, Rest & Thoma (1985) indicated the P score is more consistent as an index of moral development. In addition, a stage score can be assigned to any respondent whose answers can consistently be identified with one of Kohlberg's six stages of moral development. Studies using the DIT alone or in conjunction with other tools include Mahon and Fowler (1979), Munhall (1980), Crisham (1981), Ketefian (1981a, 1981b), Mayberry

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(1986), Bridston (1982), Felton and Parsons (1987), Frisch (1987), and Mustapha and Seybert (1989).

The JAND (Ketefian, 1982) is a self-administered objective tool which includes six incidents about nurses involved in ethical dilemmas. Subjects respond with a "yes" or "no" to a list of six to seven nursing actions. The first column, A, measures professionally ideal moral behavior, and respondents indicate whether they believe the nurse depicted in the dilemma should or should not act in a certain way. The second column, B, measures perception of realistically likely moral behavior. Respondents then indicate if they believe the nurse is likely to act as indicated in the first column. Studies using the JAND alone or in combination with other tools include Ketefian (1981b, 1985), Gaul (1986), and Cassidy and Oddi (1988).

In addition, a number of other tools were used in conjunction with the DIT (Rest, 1979) or the JAND (Ketefian, 1982). Crisham (1981) reported on the development of the Nursing Dilemma Test (NDT) to measure nurse's responses to dilemmas and the importance given to moral issues. The NDT used the DIT as a prototype for development. Felton and Parsons (1987) asked subjects to complete both the DIT and a tool they developed, the Attribution of Responsibility (AR) instrument. The researchers' purpose was to determine the influence of level of formal education to ethical/moral reasoning, attribution of

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responsibility, and ethical/moral dilemma resolution. Attribution of responsibility scores did not vary for the different educational groups, however. Ketefian (1981a; 1981b) used the Critical Thinking Appraisal Test Form ZM (Watson & Glaser, 1964) and DIT in her development of the JAND. Finally, Cassidy and Oddi (1988) asked subjects to complete both the JAND and Nursing Autonomy and Patient's Rights Scale (NAPRS) (Pankratz & Pankratz, 1974) in order to determine differences in perceptions of ethical dilemmas and attitudes toward autonomy. Significant differences were found among nursing students enrolled in different levels of nursing programs concerning autonomy, patients' rights, and rejection of traditional role limitations.

Pinch (1985) asked freshman, seniors, and graduate nurses to fill out a researcher developed questionnaire examining decision making and the shortened Nursing Autonomy and Patients' Rights Scale (Pankratz & Pankratz, 1974). This study was conceptually based on Kohlberg, even though less typical research tools were used. Results indicated freshmen were less likely to select an autonomous nursing model, had lower attitudes toward autonomy, and were less willing to be risk takers than seniors and graduate nurses. Freshmen's viewpoint is in keeping with the traditional role of the nurse, which most likely came from family and society. It appears, despite the recent advances made in

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nursing, that society's image of nursing does not match the profession's vision.

Ethical Content/Course

A number of research studies purported to determine the effect of specific ethics content on moral reasoning and judgment. Bridston (1982) reported a positive change in the measure of moral reasoning (P score) on the DIT from pretest to post-test after dilemma discussions throughout a semester. Technically, the change lacked statistical significance, however. Frisch (1987) determined that the DIT stage score showed a statistically significant positive difference between an experimental group who received instruction on nursing ethics using a value analysis method and a control group which received no additional emphasis on ethical issues.

The DIT (Rest, 1979) was used by Mahon and Fowler (1979) to identify a statistically significant increase in moral reasoning (P score) between a control and experimental group. The experimental group received planned moral content in brief "nursing rounds" format, while the control group was not given any additional emphasis on ethics except as material was normally integrated into pediatric and obstetric lectures. Gaul (1987) used the JAND (Ketefian, 1982) to study the effect of a course in nursing ethics on the ethical choice and action of baccalaureate nursing students. Scores of groups enrolled in an ethics course

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were higher than those not enrolled in such a course. Cassidy and Oddi (1988) determined that students who had completed a course on ethics scored higher on autonomy and rejection of traditional role limitations.

The results of the above cited studies lend support to the inclusion of a specific ethics content in nursing curricula, rather than relying on the integration of content. Unfortunately, the ethics material and approach to teaching varies significantly from study to study, so it is difficult to conclude how much content is enough and what approach is most effective. Case studies are used consistently, however, and Frisch's (1987) findings indicated that using ethical dilemmas derived from students' own experiences is more meaningful.

Educational Level

Educational level appears to be related to moral development in nursing research studies. Crisham (1981) determined that in 225 students studied, higher levels of moral reasoning developed with increasing education, except for an unexplained pre-nurse group enrolled in a private liberal arts college. Felton and Parsons (1987) used the DIT (Rest, 1979) in determining that graduate students had a higher overall index of principled reasoning (D score) than undergraduate students. Davis (1981) showed that diploma prepared nurses gave fewer definitions of ethical dilemmas than baccalaureate prepared nurses. Mustapha

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and Seybert (1989) determined that in a sample of 266 male and female liberal arts college students, those enrolled in an integrated curriculum organized around decision making and moral choices, scored higher DIT P scores than did nursing majors. The nursing majors had significantly higher DIT P scores than liberal arts majors enrolled in a traditional curriculum, however.

Mayberry (1986) asked 167 staff nurses and head nurses to complete the DIT (Rest, 1979). Education was most consistently related to principled decision making. The number of years of formal education was positively associated with higher P scores. The DIT was used by Munhall (1980) to determine the levels of moral reasoning of baccalaureate nursing students in each of the four academic years and faculty in the same program. The stage score indicated the average level of moral reasoning for the baccalaureate nursing student was at the conventional level while faculty reasoned at the higher principled level. The D scores indicated a significant difference in levels of moral reasoning between nursing students and faculty.

Ketefian (1981a, 1981b) studied critical thinking as measured by the Critical Thinking Appraisal Test Form ZM (Watson & Glaser, 1964) and moral reasoning as determined by the P score on the DIT (Rest, 1979). These scores were found to be positively correlated. In addition moral reasoning by nurses with baccalaureate or higher degree preparation was significantly

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higher than by nurses whose highest degree obtained was an associate degree or diploma. Finally, critical thinking and educational preparation together more closely predicted moral reasoning than either variable independently.

Cassidy and Oddi (1988) studied randomly selected students enrolled in associate degree, generic baccalaureate, degree completion, and master's study. Using the JAND (Ketefian, 1982) and the Nursing Autonomy and Patient's Rights Scale (Pankratz & Pankratz, 1974) the researchers determined that no differences were found among the four subgroups concerning perceptions of idealistic and realistic moral behavior. This is in conflict with previously cited studies. The authors suggest that "the unsatisfactory reliability of the JAND in this study and the failure of its subscores to correlate significantly with any other variable may account" (p. 409) for these findings.

Summary of Nursing Education Research on Moral Development

Methods for teaching ethical content presently described in the nursing education research literature are based on Kohlberg. It has been determined that students increase their moral reasoning ability, as defined by Kohlberg, with exposure to specific ethics content rather than relying on integration of such content throughout the curriculum. Also, advanced education stimulates moral development. Greatest differences in moral development were found in research comparing nurses completing

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undergraduate and graduate degrees (Felton & Parsons, 1987; Munhall, 1980).

As noted, the amount of ethical material included and approach to teaching varies greatly from study to study. It is difficult, if not impossible, to outline the "best" approach to the inclusion of ethics in the curriculum. Vito (1983) and Feather and Abbate (1985), among others, have suggested methods not totally validated in nursing education research, but nevertheless based on Kohlberg. These methods consist of using controversial case studies ideally drawn from the students own experiences. In small groups individuals are challenged with moral dilemmas for which their stage of reasoning provides no easy solution. Solutions and reasonings of the next higher stage are also presented. The internal uncomfortableness that results motivates student progression to higher stages of moral development. Although difficult to control with large sample sizes, research is sorely needed to determine if these techniques or other approaches are truly the most effective.

### Moral Development and Additional Variables

In addition to the importance of education in terms of moral development, researchers have attempted to link moral development and/or moral reasoning to other variables. Again, all of these studies identified Kohlberg as a conceptual base supporting the

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study. These studies will be reviewed under the headings of personal characteristics and professional attributes.

## Personal Characteristics

Most authors have asked subjects to complete demographic data forms and have proceeded to look at the relationship of personal characteristics to moral development. The findings have been unconclusive, if not contradictory. Mustapha and Seybert (1989) noted that female college students had a significantly higher DIT P score than did male college subjects but not a higher DIT D score. This finding is in disagreement with Gilligan's (1982) work and has not been studied in additional nursing research since nursing samples are almost exclusively female.

Age has been found to be unrelated to moral development in most studies (Munhall, 1980; Ketefian, 1981a; Mayberry, 1986; Cassidy & Oddi, 1988). Ketefian (1985) reported, however, that nurses over 46 years old had significantly higher moral behavior scores than younger nurses between the age of 26 and 35 years. Cassidy and Oddi did determine that younger students scored significantly higher on autonomy, patients' rights, and rejection of traditional role limitations subscales. Analysis of the variables of economic level, parents' occupation, previous nursing experience, and religion were not significant in Munhall's study, although higher grade point averages were

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associated with higher levels of moral reasoning. Ketefian also did not find a relationship between religion, ethnicity, and moral reasoning.

Crisham (1981) reported that non nurse and prenurse groups had higher scores measuring the importance given to principled moral considerations than staff nurses with experience. In explaining this, she described a hospital milieu effect that may bring about a variation in dealing with moral issues. It is plausible that staff nurses interpret ethical dilemmas in terms of conflicting pressures and obligations within the hospital environment. Carefully considered moral judgments may be altered by opposing loyalties, distractions, and contrary expectations. Mayberry (1986) similarly found that nurses with fewer years of experience immediately following formal schooling, exhibited greater principled reasoning ability. Of particular significance in her study was the fact that head nurses scored at the lower conventional level of reasoning which measures obedience and respect for authority. As nurses gain more experience Mayberry reports, "they become imbued with the organization's aim and develop loyalty to the institution and to peers" (p. 79). Ketefian's (1981b) research also validated that nurses with less than one year of experience had higher scores measuring professionally ideal moral behavior than nurses with 10 or more years of experience.

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## Professional Attributes

Researchers have also associated a number of professional attributes to moral reasoning. Although results are not definitive, some of these studies suggest a relationship between moral development and desirable professional behaviors.

Felton and Parsons (1987) found no significant correlation between dilemma resolution on their author developed Attribution of Responsibility Instrument and overall moral reasoning levels measured by the Rest's DIT (1979). Pinch (1985) was also unable to identify significant relationships between risk-taking, autonomy, restrictions, anxiety, and use of a patient advocate model based on principled moral reasoning.

Ketefian (1981a) however, reported a correlation between critical thinking scores as measured by the Critical Thinking Appraisal Test (Watson & Glaser, 1964) and the DIT (Rest, 1979) P score significant at the .001 level. She additionally determined that critical thinking and education accounted for 33 percent of the variance in moral reasoning. Fleeger (1986) also found a significant relationship between critical thinking and moral reasoning in a cross sectional population of nursing students using the same tools as Ketefian.

In 1985, Ketefian tested the relationship between professional and bureaucratic role conceptions and moral behavior in 217 practicing nurses. Professional role conception referred

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to the individual's value orientation with regard to the nursing profession, (i.e., commitment to practice standards, involvement in professional organizations). Bureaucratic role conception referred to values of loyalty to the employing institution and following administrative rules and routines. Each of the role conceptions was broken into two subscales: the normative scale which described the ideal nursing role and the categorical scale which reflected a perception of actual practice of the role. The professional, categorical role conception was positively related to moral behavior, while the professional, normative role conception was negatively related. Additional analysis was not definitive, but suggested that the professional role conception is a better predictor of moral behavior than the bureaucratic role conception.

Summary of Moral Development and Additional Variables

Little definitive evidence exists for relationships between additional variables other than education and moral development. Researchers have attempted to associate demographic factors with little success. Most interesting may be the significant increased moral reasoning in nurses with less professional experience as compared to those with more experience. It is also significant to note the relationship between critical thinking, the professional categorical role conception, and moral behavior.

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## Non-Kohlbergian Conceptually Based Studies

Other than a survey by Davis (1981) that identified no conceptual base, only one other research study did not purport to be conceptually based on Kohlberg. In Davis' survey, ethnicity and religion were not associated with any ethical dilemma variable but education was a factor in how ethical dilemmas were described. Diploma nurses related fewer ethical dilemmas than baccalaureate nurses. Ethical dilemmas were also more frequently reported among younger nurses. Swider, McElmurry, and Yarling's (1985) research was conceptually based on the ANA Code (1976) and literature in nursing ethics (Aroskar, 1980; Gadow, 1980; Murphy, 1982). Priorities in decision making reported by 775 senior baccalaureate nursing students in 16 mid-western colleges and universities were examined when presented with an ethical dilemma. In small groups of five, the students arrived at a course of action to deal with the dilemma. Of 1,163 recorded decisions, 9% were patient-centered (i.e. reflecting nursing responsibilities to the patient/family), 19% were physician-centered (i.e. reflecting nursing responsibilities to the physician), and 60% were bureaucratic-centered (i.e. reflecting nursing responsibilities to the hospital or institutional system). The remaining 12% were categorized as other. This finding is important in understanding ethical decision making in

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professional practice and the influence of social or bureaucracies on nursing roles.

Unethical Behaviors of Nursing Students and Faculty

Hilbert (1985, 1987, 1988) has published a series of articles on unethical classroom and clinical behaviors of nursing students. Examples of unethical behaviors of nursing students included copying during an examination or quiz, not footnoting a reference in a paper, discussing patients in public places or taking hospital equipment for use at home. Her 1985 study documented the incidence of unethical classroom behaviors for senior nursing students to be less than the number reported for college students in general. However, one must be concerned about all unethical behaviors in students studying to embark on a career with the responsibility nurses have. In addition, Hilbert (1987) also documented a significant correlation between unethical classroom and clinical behaviors. A student who acts unethically in the classroom must be observed closely in clinical practice. Demographic variables (age, sex, GPA, and ethnic background) were not significantly related to unethical behavior.

In 1988, Hilbert determined there was no relationship between unethical classroom behaviors and the level of moral development as measured by the DIT (Rest, 1979). A statistically significant relationship was identified concerning the level of moral development and unethical clinical behaviors. Reasons

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explaining why moral development was related to clinical and not classroom behaviors remained speculative, but may center around the fact that behavior in the clinical area directly affects the welfare of others.

The profession of nursing, and certainly nurse educators, have reason to be concerned about the high incidence of unethical behaviors. Throughout Hilbert's 1985, 1987, and 1988 studies, 16 to 25 percent of the student subjects admitted to recording medications, treatments, observations or home visits that were not done. Close to 50 percent conceded that they have taken hospital equipment to use at home. Approximately 75 percent reported discussing patients in public places or with nonmedical people. These high percentages are viewed with additional concern since it is likely that unethical behavior is significantly underreported.

Carmack (1984) explored one aspect of students' unethical behavior, plagiarism. Using a nonexperimental descriptive design, 21 faculty members from across the United States were interviewed. Even though not every faculty member interviewed had been directly involved in a plagiarism incident, each was able to describe at least one example of student plagiarism. Half of the subjects thought plagiarism was common. Eleven subjects believed a relationship between academic dishonesty and

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clinical dishonesty exists as was later documented by Hilbert (1988).

Theis (1988) studied the other side of the coin, unethical teaching behaviors. Only 34 of 204 students indicated they had not confronted any unethical teaching behaviors. In both the classroom and clinical setting, respect for persons was the most commonly violated ethical principle. The study described students' perceptions about teaching behaviors, which may have been misinterpreted. Teachers' actions speak very loudly, however. How can we teach students to be caring and respectful toward patients if they are not treated that way by faculty?

Based on the research concerning unethical behaviors of nursing students and faculty, it would be prudent for nursing educators to be concerned about unethical classroom and clinical behavior by students. Hilbert's (1985, 1987) research also suggested that students were more likely to respond ethically if academic fraud and cheating policies were enforced consistently and if assignments were meaningful and reasonable. Nursing faculty must also examine their own teaching behaviors, particularly in terms of violation of respect for persons.

## Qualitative Studies

Wilkinson (1987/88) explored the phenomenon of moral distress as experienced by hospital staff nurses using a qualitative approach. Data were collected through face-to-face

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interviews with 13 staff nurses and 11 nurses who had been (but no longer were) staff nurses. A narrative description of moral distress was presented and supported by a significant amount of verbatim interview material. The moral distress experience was summarized in an equation. Additionally the experience of moral outrage was identified which resulted in similar effects on nurses, but the process involved actions taken by someone other than the nurse.

This study is significant to the research presented here because it is one of the few qualitative nursing ethics studies published that attempts to understand a moral phenomenon. Cases mentioned most often by nurses were those concerned with: a) prolonging life, b) performing unnecessary tests and treatments, c) situations involving lying to patients, and (d) incompetent (inadequate) treatment by a physician. Subjects perceived that moral distress occurred frequently in practice. The author suggested she did not intend to generalize about the frequency, but only three of the 24 nurses indicated moral distress occurred less frequently than once a week.

All subjects identified several external and internal constraints to any course of moral action they may have chosen to take. Moral distress was felt to be detrimental to the nurses' personal or professional life but they did not perceive that moral distress had much effect on quality of care. Wilkinson

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(1987/88) speculated that patient care may have been affected more than the nurses believed. Coping behaviors were discussed. Unsuccessful methods of coping included avoidance of patients or entire job situations. Successful coping mechanisms, from the author's perspective, involved denial of responsibility for the situation or moral actions and/or the belief that they had some control over and effect on patient care.

Use of Interpretive Method of Data Analysis

The interpretive method of data analysis has been recently described in depth by Brown (1988). Thus far its use is somewhat limited. Brown (1989) used the technique to describe how a perspective of care was identified in girls attending a private all-girls school as they made moral decisions. Age distinctions in the articulation of the care perspective were apparent. These distinctions can be interpreted in the realm of cognitive-developmental psychology, as progressions reflecting increasing cognitive complexity. They also can be identified as a series of female responses to pressures confronting women at all ages to adapt to cultural norms, values and definitions of women. This latter identification suggests that female development is greatly affected by sex-role stereotypes and socio-cultural expectations.

Gilligan, Johnston and Miller (1988) reported on adolescent development in educationally advantaged males and females with respect to self-description, moral conflicts and choices, and

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relationships with others. The study was a three year longitudinal research project from which five doctoral dissertations were completed. Both similarities and differences were identified. Males and females describe themselves in terms of achievements as well as being of help to others. The students were able to articulate conflicts in relationships and used both a justice and care perspective in working through their dilemmas. Friendships were of prime significance for both males and females. The following differences between sexes were also noted: females are more likely to describe themselves in relationships with others; females are also more likely to voice concerns about attention, care and connections between self and others than males; and females struggle with the question of how to include themselves in relationships whereas males are more concerned with how to include others.

## Review of Literature Summary

Research designs used in moral development studies in nursing were generally descriptive. Those studies based on Kohlberg asked participants to complete questionnaires, most commonly the Defining Issues Test developed by Rest (1979) and Ketefian's Judgments about Nursing Decisions (1982). Demographic information was collected. Three studies used a quasi-experimental design. Ketefian and Ormand (1988) also did a review

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of literature on moral reasoning and ethical practice. Their findings validated those of this author in the following areas:

1) The relationship between moral reasoning and education remains slightly ambiguous but appears to be positively related to critical thinking, intelligence, grade point average, and years of education completed.

2) The relationship between moral reasoning and moral behavior remains unclear.

3) Research is not cumulative. Investigators have not learned from or built on the work of predecessors.

4) Most studies examine the affect of one or two selected variables on either moral reasoning or ethical practice. Ethical issues, however, by their very nature are so complex that multivariate research strategies are required to explain the phenomena more effectively.

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# CHAPTER III

## RESEARCH METHODS

This study provides information about the perspective registered nurses use to make moral decisions. Earlier research in this area was based on Kohlberg's (1971, 1973, 1976, 1978) theoretical conception of moral development. That base, however, does not appear to be comprehensive, inconclusive of women's experiences, or based on real life dilemmas. This researcher was interested in describing how moral decisions are made from Gilligan's (1982, 1987) and Gilligan and Attanucci's (1988) broader theoretical approach. It was also recognized that more perspectives may be involved in moral decision making than the frameworks identified by Gilligan.

### Research Questions

1) To what extent is a care perspective used by registered nurses as they make moral decisions?
2) To what extent is a justice perspective used by registered nurses as they make moral decisions?
3) To what extent do registered nurses combine the justice and care perspective as they make moral decisions?
4) Can any additional perspectives be identified that do not clearly fit into the care or justice perspective?
5) How do demographic variables relate to the perspectives used by registered nurses to make moral decisions?



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## Definition of Terms

Moral decisions are defined as decisions in which there is no clear right or wrong answer. A resolution is arrived at by weighing alternatives and deciding which action should take precedence in the situation.

Moral development is a developmental process of moral reasoning depicting transformation in the way ethical dilemmas are interpreted. Each successive stage is purported to be more complex, comprehensive, and effective than the preceding stage for handling moral dilemmas. Individuals procede through theorists identified universal stages that follow laws of development (Ketefian, 1981b, Rest, 1976).

A care perspective is concerned with "the complexities of sustained attachment" (Brown, 1988, p. 4). The perspective will be identified by listening to nurses describe situations in which moral decisions were made through a care orientation. In solving moral conflicts from the perspective of care, value is "placed on maintaining connection, not hurting, attending, and responding to need" (Brown, p. 94).

A justice perspective is concerned with "issues of fairness, individual rights, and adherence to standards or principles" (Brown, 1988, p. 4). The perspective will be identified by listening to nurses describe situations in which moral decisions were made through a justice orientation. In solving moral

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conflicts from the justice framework one is concerned with problems of inequality and the importance of treating all involved (including self) with equal respect. Conflicts are resolved by "'weighing' competing claims, as well as deciding whether potential negative consequences outweigh positive benefits" (Brown, p. 111).

A combined care and justice orientation is concerned with both perspectives as defined above. Such a combined predominance will be identified by listening to nurses describe situations in which moral decisions were made through both a justice and care orientation. Combined perspectives in a passage of the text are apparent when the narrator has joined both a care and justice orientation in such a way that the true meaning of the passage can only be understood by attention to both modes of decision making.

Additional perspectives in making moral decisions will be identified when neither the care nor justice framework adequately explain how the moral decision was made. This may involve a totally new perspective that has not yet been identified.

## Research Design

The design of this research study was descriptive with the aim of explaining moral decision making by registered nurses within the setting of a neonatal intensive care unit. Figure 1

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adapted from Burns and Grove (1987) illustrates this descriptive study design.

The figure suggests that the phenomenon of moral decision making was interpreted from a number of perspectives. A description of those identified perspectives follows. The research process concludes with an explanation of the perspectives used by neonatal nurses to make moral decisions.

Moral decision making was examined using an interpretive method described by Brown (1988) in the Guide to Reading Narratives of Conflict and Choice for Self and Moral Voice. The guide provided the methodological foundation for this study by highlighting the way in which self is represented in the two voices or perspectives of care and justice. The reader was attuned to the person speaking in the interview as they discussed a professional moral conflict in terms of concerns about justice and care. Thus, the method outlined a particular way of interpreting moral dilemmas. It clarified the research approach described by Gilligan and her associates (Gilligan, 1987; Gilligan & Attanucci, 1988; Brown, 1989; Gilligan, Johnston, & Miller, 1988; Gilligan, Brown, & Rogers, 1988). Additional discussion of this method is included under the data analysis section.

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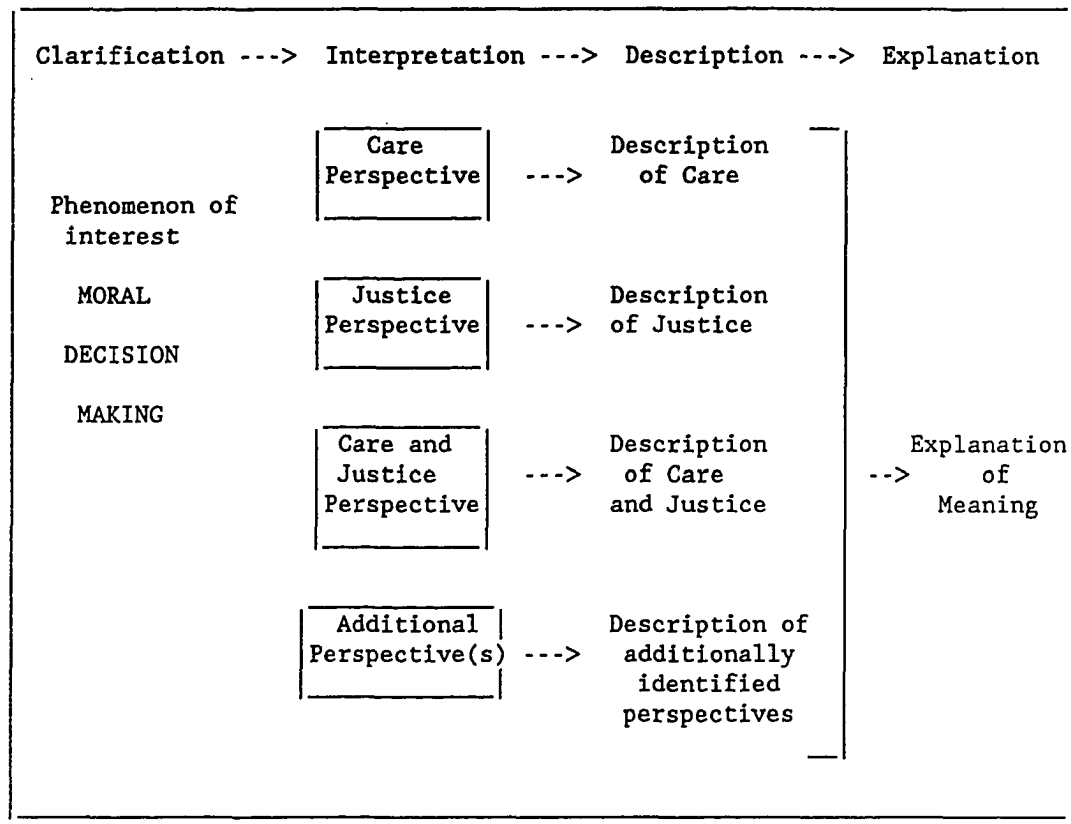
Figure 1. Illustration of descriptive study design.




Pilot Study

In the Fall of 1989 a pilot study was conducted to test the aims and methods of the study and the feasibility that the questions proposed by the researcher would yield the data needed to meet the purpose of the study. A sample of three neonatal intensitve care unit nurses were interviewed. One was a staff nurse who worked per diem, one was a full time staff nurse, and the third was the head nurse in a large level III nursery.

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Results of the pilot interviews were discussed with the chairperson of the student's dissertation committee. It was decided to limit the sample to nurses who directly cared for babies rather than including nurses holding administrative positions. The head nurse interviewed described very different ethical dilemmas than had the staff nurses. In addition it seemed reasonable to limit the sample to nurses working in one large neonatal intensive care unit if an adequate number were willing to be interviewed. The worthiness of the study was also reinforced, since identifiable trends seemed promising even after just three interviews.

## Setting

The setting for the study was a level III neonatal intensive care unit in Chicago, Illinois. This unit served as a resource of nurses who were willing to discuss moral dilemmas in their clinical practice. A level III, or tertiary facility, provides sustained and total care for the most complex obstetrical and neonatal problem (Vestal & McKenzie, 1983). The unit was associated with a medical and nursing school. Agreements to transport complex cases to this unit from facilities with less expertise and equipment existed. Extensive and ongoing education was available for personnel.

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## Sample

The sample was drawn from female neonatal intensive care nurses who have at least one year of experience and were working at least 20 hours per week in level III neonatal intensive care units. Registered nurses meeting the above criteria were contacted personally and invited to participate in the study.

The researcher spent two to three days per week at the neonatal intensive care unit interviewing nurses. Interviews were scheduled at times convenient to the nurse being interviewed, and when nurse colleagues were willing to cover for and meet the needs of the informant's babies. All who agreed to talk to the researcher and had time to do so when the researcher was at the unit were interviewed.

Twenty-six registered nurses comprised the sample. This number is deemed adequate based on the number of subjects in similar research done on this topic (Gilligan, 1977, 1982; Brown, 1989; Gilligan, Johnston, & Miller, 1988), keeping in mind the intensity of the interview process and data analysis techniques. As described in the procedures section, all nurses interviewed were from Rush-Presbyterian-St. Luke's Medical Center. The researcher arbitrarily assigned numbers to each interview. During week one of data collection, the researcher numbered the first interview 10 and continued to number 13. Four interviews were obtained that week. Week two, the researcher started with

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the number 20. The interviews week three were numbered in the thirties, those week four in the forties and those week five in the fifties. As a result, assigned interview numbers range from 10-57 even though only 26 nurses were interviewed.

## Instrumentation

The interview guide was developed based on the researcher's own experience as well as the Real Life Moral Conflict and Choice Interview Guide developed by Gilligan and her associates (Brown, 1988).

The following questions were asked of neonatal intensive care nurses:

1) Looking over your recent professional past, what stands out for you?

2) All nurses indicate they have had the experience of being in a situation where they had to make a moral decision but were not sure of what they should do. Could you describe a situation when you were faced with a moral conflict and had to make a decision about what to do?

3) What was the conflict in the situation for you? Tell me more about the conflict.

4) In thinking about the dilemma, what did you consider? Can you tell me more about that? Anything else?

5) What did you decide to do?

6) What happened?

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7) Do you think it was the right thing to do? Why or why not?

8) What was at stake for you in the dilemma? What was at stake for others?

9) How did you feel about it? How did you feel about it for the other(s) involved?

10) Is there another way to view the problem other than how you described it?

11) When you think back over the conflict you described, do you think you learned anything from it?

12) Do you make moral decisions differently than you used to? How has the process changed? What helps you? What hinders you?

13) What does morality mean to you? What makes something a moral problem for you?

The researcher believed that all questions related to the basic purposes of the study, i.e., to understand how nurses make moral decisions. In addition the interviewer asked clarifying questions about the moral dilemma, its resolution, and evaluation of the choice made.

Interviewees were also asked to fill out a demographic questionnaire requesting personal, professional, and employment setting information. (See Appendix A) The demographic questionnaire was a variation of that used by Penticuff (1989).

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The information requested was significant in terms of how ethical decisions are made by nurses practicing in neonatal intensive care units.

## Procedures

Top level nursing administrators were contacted in hospitals with level III neonatal intensive care units in the Chicago area to ask their permission to conduct the study. After initial contact with numerous level III nurses, it was decided to begin collecting data at Rush-Presbyterian-St. Luke's Medical Center intensive care nursery because of the size of their unit and their eagerness to support nursing research. The purpose and methodology were shared with the neonatal intensive care unit's head nurse and charge nurses. Staff nurses were then contacted by the researcher on days she could be at the hospital and asked to volunteer to talk about their experiences of moral decision making. Interviews were scheduled at convenient times for the informant. Since an adequate number of nurses could be interviewed at Rush-Presbyterian-St. Luke's Medical Center, all of the sample is from that institution.

Data were obtained through a format of audiotaped semi-structured interviews and a demographic questionnaire. The interviews lasted approximately one half hour as an average, but all nurses were given time to adequately describe a real-life

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moral conflict. Interviews were conducted in a lounge or quiet corner of the unit.

Prior to the interview the purpose of the study was explained. Each nurse was asked to sign a consent form. A copy is included in Appendix B. The only risks associated with the study were mild anxiety and/or frustration evoked by redeliberation of a moral dilemma. Raw data were accessible only to the researcher, her dissertation committee and transcribing secretary. The participants received no direct benefits of participation in this study but the results will benefit nurses making later moral decisions as additional educational strategies are identified and improved. In light of this, risks appeared small and the potential outcomes may benefit many nurses. The purposes and methods of the study were approved by the Human Subjects Research Committee of the School of Nursing in the College of Health Sciences at Georgia State University, the Research Review Board at Northern Illinois University and the Human Investigation Committee at Rush-Presbyterian-St. Luke's Medical Center.

## Limitations

1) There may be unaccounted differences in nurses who chose to discuss moral dilemmas with the researcher and those who did not.

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2) Differences in moral decision making in only one care setting were addressed.

3) The recount of the moral dilemma was what the nurse remembered and believed to be true.

## Analysis of Data

Descriptive statistics were appropriate for data analysis in this study. Such statistical techniques summarized in a precise yet standard way, the characteristics of the data gathered. The characteristics include demographic information, interview data and relationships between the data. The majority of data collected was at the nominal level; therefore, the descriptive statistical methods used include frequency distributions, measures of central tendency and contingency tables.

In addition, there was rigorous analysis of the narrative interview data to understand in a personal way (Carper, 1978) the perspective nurses used to make moral decisions. This was striving as if the other's experience of making moral decisions were the researcher's own. According to Swanson-Kauffman and Schonwald (1988) such data analysis involved: a) very attentive listening to the informant, b) believing the informant was an expert on the topic of inquiry, c) creatively assisting the informant to reflect on the meaning of the events discussed, and d) finally moving to an understanding of moral decision making.

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The specifics of data analysis using the interpretive method were described in detail by Brown (1988). All interviews were transcribed. The researcher began by identifying a real-life moral conflict from the interview. The narrative was then read at least five different times. Each time a specific voice or approach was listened for.

During the first reading one received an overall sense of the story as told by the interviewee. The focus was on the meaning of the tale. The goal was to understand what was said and hear the narrator's story as clearly as was possible.

The second reading focused on the self. The reader concentrated on the person who was talking, opening eyes and ears to the other. The way the narrator spoke about herself was amplified to comprehend how the self was understood in relationship to the action taken. The reader listened for ways the self was spoken about and began to respond emotionally as well as intellectually. A process of connection developed between the reader and presenter, creating a channel through which information could flow.

The third reading was for care. At this time voices were listened for that spoke about "not hurting, paying attention, taking action, and creating connection" (Brown, 1988, p. 13). A web of interdependence was an organizing image of this orientation. Attention was drawn to problems of attachment and

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detachment. Value was placed on "knowing" the other and recognizing his/her needs. A care orientation focused on the specifics of a situation and attempted to meet the needs of others involved in the conflict.

The fourth reading, for justice, listened for discussions concerning treating others fairly and maintaining standards. An organizing image for this orientation was "scales of justice" (Brown, 1988). The narrator discussed the notion of balancing or equalizing viewpoints. Dilemmas were settled by weighing the importance of competing claims and also deciding whether possible negative consequences outweigh positive advantages. One desired to be impartial and fair based on universal principles. There was an attempt to remove oneself from relationships and individual interests.

The fifth reading, for any additional perspective(s), was based on the premise that nurses making moral decisions in a professional setting operated from more than a justice and care perspective. It was very possible that responsibility to the employing institution, relationships with physicians, other co-workers concern for clients, and the nurse's personal values interplayed in such a way that neither care nor justice could totally describe the perspective moral decisions were made from. Material that did not seem to fit in the care and justice

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category was identified and analyzed for identification of any additional orientations.

Each reading was as looking at the story through a different lens. Certain passages had varying meaning depending on the lens through which it was observed. A meaning became apparent with one lens but was obscured from view with another. Passages in the interview text illustrative of each reading--self, care, justice and any additional perspective--were underlined in different colors. This visual technique keyed the reader in to specific language without losing sight of the totality of the larger story.

A summary interpretation was then written. The summary interpreted perspectives discussed by the narrator, described the predominance of one perspective over others, and determined the alignment of self with the moral orientation. This was the last step in the process of interpreting a narrative of moral decision making and was constructed from previous readings of the interview.

Included in Appendix C is the Data Analysis Work Sheets and Summary Coding Form adapted from Brown (1988) that were used to analyze the narrative data collected in the interviews. Specifically outlined is what the researcher was looking for within the interviewee's discussion of moral conflict. The Summary Coding Form allowed the researcher to quantify nominally

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the narrative orientation, allowing for additional description and analysis of data. Groups of narratives were then compared to specific demographic data.

Evidence was presented by Brown (1988) that the interpretive method is reliable, i.e., the ability of two or more different readers to agree on their interpretation and understanding of a specific interview exists. Expert readers have been compared to trained graduate students. Reliability figures between the two groups "represent levels of 'fair' to 'almost perfect' agreement beyond chance" (Brown, p. 147).

Construct validity of the interpretive method was also discussed by Brown (1988). The reported findings are preliminary, but indicate that the approach does discern a gender difference and a context effect as care and justice are represented in real-life moral dilemmas.

The researcher then recorded all of the responses given by nurses which related to a perspective of moral decision making. Patterns were noted and categories of answers began to develop. This served as an outline for the researcher as she began to write the results. Additional patterns were identified throughout the process of writing results. All tapes, transcribed interviews and notes remain available for review.

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## Differences from Previously Published Studies Using the Interpretive Method

This study was based on a methodology and data analysis techniques similar to work described by Brown (1988, 1989) and Gilligan, Johnston and Miller (1988). Although the techniques described in this study were similar, the following differences are noted:

1) The subjects interviewed in this study were discussing moral dilemmas occuring in professional experiences. Previous research has centered on dilemmas that are personally significant.

2) The studies cited above were based on the premise that only a care and/or justice orientation are used to resolve ethical dilemmas. This researcher entertained the possibility that additional perspectives may be identified.

3) Much of Gilligan's and her colleagues' research has been with adolescents, although certainly not exclusively. Recent reports published from the Harvard University Center for the Study of Gender, Education, and Human Development discuss school children (Brown, 1989; Gilligan, Johnston & Miller, 1988; Rogers & Gilligan, 1988). This study interviewed adult women.

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# CHAPTER IV

# FINDINGS

## Introduction

The purpose of this research was to gain information about the perspective neonatal intensive care nurses use to make moral decisions. Previous research in nursing has assumed acceptance of Kohlberg's theoretical conception of moral development developed from longitudinal research with males. Use of Kohlberg's (1978) model has significant implications for nursing since it represents only one perspective of moral decision making. This descriptive research incorporated recent moral development theory and methodology to include not only the Kohlbergian justice perspective, but in addition, the care perspective described by Gilligan (1982, 1987). From analysis of the data, the researcher hoped to identify the perspective nurses used to make moral decisions. It was recognized that a perspective combining both care and justice may be identified or that a different perspective may emerge.

Research questions included:

1) To what extent is a care perspective used by registered nurses as they make moral decisions?
2) To what extent is a justice perspective used by registered nurses as they make moral decisions?



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3) To what extent do registered nurses combine the justice and care perspective as they make moral decisions?
4) Can any additional perspectives be identified that do not clearly fit into the care or justice perspective?
5) How do demographic variables relate to the perspectives used by registered nurses to make moral decisions?

The issue of moral voice was central to this study. By moral voice was meant the way in which a person, (in this study a registered nurse), spoke about herself and relationships, as well as how self affected the thoughts and behavior surrounding moral dilemmas. Using the data analysis work sheets (see Appendix C) to analyze moral conflicts, the justice and care perspectives were identified. Although both justice and care were heard in all interviews, the predominant moral voice meant the orientation which was most prominent for the nurse in discussing a moral dilemma. The nurses interviewed all began by representing more than one perspective, but most gave a more complete elaboration of one voice, thus subordinating the other. The predominant perspective merged as salient when the interview continued. In some cases, neither justice nor care predominated. They were both integrated throughout the interview, but neither more eminent. Predominance was a perspective tied to specific content as will be illustrated. This chapter will present the results of the study.

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Before addressing the specific research questions, Table 1 is presented as an overall analysis of moral voice predominance. Care is the moral voice of predominance as evidenced by 65% of the nurses describing a dilemma from that perspective. The care/justice perspective was used by 23% of those interviewed and the justice orientation by only 12%.

Table 1

Predominance of Moral Voice

| Moral Voice | Number | Percentage |
|---|---|---|
| Care | 17 | 65 |
| Justice | 3 | 12 |
| Care/Justice | 6 | 23 |
| Totals | 26 | 100 |

Question One

To what extent is a care perspective used by registered nurses as they make moral decisions?

Without exception, every one of the nurses expressed an understanding of the care perspective. In addition, as previously noted, 65% of the nurses interviewed identified care as the predominant perspective used when deciding about a moral dilemma. Various methods of expressing care were

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identified throughout the interviews of neonatal intensive care nurses. The following discussion supports establishing a care taxonomy.

## Care Taxonomy

### Not Hurting

Care took the form of protecting the babies from pain and hurt. The following examples include:

"I felt . . . like we were torturing this baby unnecessarily and I had to do most of it" (Interview 31, p. 3).

"So it was real hard to take care of the baby and you know they're in pain. You just don't know how much" (Interview 20, p. 3).

"It's a hard thing to see a baby go through that much pain. It hurts. I just hate doing everything to it. . . . It's like I'm doing it to myself" (Interview 21, p. 3).

"You see them go through so much torture . . . so much pain and discomfort. . . . I feel it is brave sometimes to stop" (Interview 24, p. 3).

> So it's actually my pain and then I feel the pain. . . . I just start getting crazy inside. I can't watch. I can't do anything more. You can just imagine what the kid is going though . . . and you have to stop it (Interview 35, p. 6).

"You could just see the little misery in his eyes. Let go, let go" (Interview 55, p. 10).

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As expressed in these examples, care called attention to physical hurt as a moral problem. Many nurses expressed concern about the pain these tiny infants had to endure. Since the babies were so young and limited in their ability to express themselves, emotional hurt was mentioned only in reference to the parents' needs, the nurses' discomforts, or what the future may hold if a severely handicapped child was allowed to continue living. When performing health care activities, it is acceptable to physically inflict pain in the guise of the suffering or discomfort being for the patient's own good. These nurses made it very clear that in their opinion there was a point when the pain inflicted was not worth any benefit that might be gained.

The issue of pain is critical in neonatal intensive care. Penticuff (1987) reported that, "in the case of infant pain, it would seem that there has been a conspiracy of silence and an unspoken agreement that perhaps if we don't talk about it, it will go away" (p. 9). In this study neonatal intensive care nurses were well aware of the suffering babies in their care endured and had difficulty justifying torture of the infants. Afterall, nursing's goal has always been humanistic compassion.

Welfare of Others

The nurses' concerns about the welfare of others were expressed in two ways. First, nurses were very attuned to the specific needs of the babies, both physically and

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psychologically. When describing care concerns in this category the nursing expertise of those interviewed was apparent. Secondly, nurses distinctly stated concerns about the babies' and parents' futures if the infants survived.

Specific needs. Examples of the nurses' particular attention to the specific needs of a baby are found in the following statements:

"I know him inside out" (Interview 10, p. 7).

"[As] the nurse who has been at the bedside for 12 hours, . . . you have a much better idea than the physician of what's going on with the baby" (Interview 57, p. 5).

Decisions made by neonatal intensive nurses were overwhelmingly based on the particular needs of a baby. Nurses reported an understanding of precisely how a baby was doing physiologically. This came from being in close contact with a baby over an extended period of time and the use of nursing skills to assess a baby's needs.

Two nurses even spoke of being aware of a baby's inner drive. One, in particular, waited to see how babies were going to do on their own before doing everything for them. She believed that those babies who end up not doing as well, were those that have less inner strength. This particular nurse had the capability to sit by a sick newborn's bedside and determine, rather quickly, who was and who was not strong willed.

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Babies' and parents' future. Nurses also expressed caring as they contemplated what the babies' and parents' futures might hold.

"I can't imagine taking a kid home . . . that are [sic] severe cerebral palsy. I couldn't imagine taking them home" (Interview 20, p. 15).

"I just have a real serious question about whether or not we should be saving [them] . . ." (Interview 21, p. 1).

"And then how is the child going to feel . . . if he comes out with severe handicaps? Would this child rather be dead and wished down the road that we hadn't saved him?" (Interview 25, p. 8).

"What if we save this baby? How normal could it possibly be?" (Interview 50, p. 3).

"Because as far as I felt if you saved this baby in the long run what is his brain going to be like?" (Interview 51, p. 5).

The nurses struggled with the quality of life babies who were discharged from the unit would experience. In addition they expressed concern over what life would be like for the parents of such infants. At times their concern about the babies' and parents' dismal futures made them question the futility of their work.

Concern over the welfare of others, either at present or in the future, is a major component of the care perspective with

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these neonatal intensive care nurses. It is not surprising to a nurse researcher that nurse colleagues are so determined to improve their patients' welfares. Improving well being is a goal of nursing care.

Attachment and Connection

Attachment and connection were very important components of the care perspective. Attachment seemed a particularly appropriate labeling of nurses' relationships with infants because of the previously described concept of infant attachment in the literature (Bowlby, 1969; Chally, 1977; Mercer, 1986). Attachment describes a relationship between two or more persons based on love and acceptance. The term, connection, describes a relationship of response to others in their own terms (Lyons, 1983). Connection indicates understanding others in the situation they are in. Nurses expressed attachment and connection to babies, to parents, and to colleagues. In addition there was much discussion of the effect of actual or potential parenting on relationships with both babies and parents.

To babies. Most nurses described strong attachment to the babies they cared for. At times the attachment was described in global terms as related by the following:

"I love the children. . . . My rationale for this is I love the children" (Interview 27, p. 1).

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At other times, emotional connection was identified towards a specific child.

"It hurts me because I did love the child" (Interview 27, p. 6).

"How far should I . . . as person who loves this kid . . . interfere?" (Interview 10, p. 3)

". . . and then I really got involved with her. Then I really loved her and I wanted her to pull through. . . . I had to go away on my honeymoon in the middle of it and I didn't want to leave" (Interview 21, p. 2).

"Then . . . I really became attached to her and wanted her to do well" (Interview 30, p. 4).

"I had a primary [baby that I was the primary nurse for] that I took care of for eight months here and . . . I was buying the baby clothes. . . . This kid was on my mind 24 hours a day" (Interview 53, p. 5).

The researcher was impressed by the extent of care expressed as attachment and connection toward the infants. These nurses were extremely fond of the babies they cared for. The babies occupied the nurses minds much longer than just while they were working. They were much more than patients in the typical nurse-patient sense.

To parents. Nurses also spoke very strongly of their attachment to the parents. In most instances, (20 out of 26

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nurses interviewed), this attachment or connection was expressed toward the parents as a couple. This fact is quite interesting as one realized many of the babies were not part of a family in the traditional sense. Fathers were often not present. The following examples illustrated the connection between nurses and parents:

"I had him everyday and I kept thinking, well maybe I should take a break but . . . what if the parents come in? . . . I'll keep taking care of him everyday in case the parents come in, more for the parents than for the baby or myself" (Interview 20, p. 8).

"I do like getting involved with the families that I've gotten involved with. . . . I need to get really involved with my families" (Interview 32, p. 1).

"We don't have just a patient. There is always a family involved" (Interview 20, p. 6).

Families were not involved with all babies in neonatal intensive care. Those families who demonstrated interest in their sick newborns appeared to be met with open arms. The nurses were very concerned about meeting the needs of families and making the time the babies were in the neonatal intensive care as easy for the parents as possible.

Effect of parenting. An interesting aspect of the caring perspective was identified as neonatal intensive care nurses

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talked about how parenting their own children had affected their work with sick newborns and parents. The following examples are illustrative:

> Well before . . . having the parents here sometimes is kind of a hassle, but now that you have your own, I would want to be there and everything so I really can relate more to the parents. . . . Even towards the babies . . . after awhile you just start doing things without thinking. . . . Now I think about this baby (Interview 31, p. 6).

"Since I'm a mother, I always have compassion for the parents. . . . I always feel this could be my baby going through this . . . and how would I feel. So I try to be understanding of the parents . . ." (Interview 20, pp. 10 & 12).

> When you have your own kids . . . it's like a part of you is being ripped apart and that's pretty much what we feel like when we're taking care of these little kids. . . . [Being a parent] is like you have another sense of feeling, another sense of pain. . . . You think of your own child, what it would be like and how you cry inside when they get a bad scrape or something (Interview 25, pp. 6 & 7).

It was surmised by the researcher that only in neonatal and pediatric units could the process of parenting have such a profound effect on nurses' feelings of attachment toward someone else's child. To understand these nurses' statements was to

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recognize that the nurses transposed the maternal bond between themselves and their children to the mother and child whom they now cared for. It is very possible, however, that the sick baby and mother have a different relationship than the nurse and her child. Regardless, after having a child of her own the nurse viewed babies she cared for as more unique individuals. She was reminded that someone actually or potentially cared about this baby much as she cared for her own.

Only 9 of the 26 nurses interviewed had children of their own. Even the idea of having a baby seemed to effect how some nurses cared for the babies, however.

"I'm approaching that time in my life when I need to have a baby. . . . I'm thinking more of the baby as a human being" (Interview 33, p. 7).

"The more I think about having a baby it's a lot harder. . . . I can really empathize or sympathize with them" (Interview 56, p. 7).

The prospect of parenting and its effect on care again seemed unique to the neonatal or pediatric setting. It is very possible working with small neonates pulls at the heart strings of potential mothers even more than working in a pediatric setting. The developmental stage of the neonate is very close to what the nurse may be anticipating with her own baby in the near future.

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To colleagues. Connection, as a form of care, was also expressed toward colleagues. Generally, fellow nurses were discussed but occasionally concern about physicians was apparent. The following examples give evidence:

"I also think about the nurses. . . . We have a real strong morale together. We are each others' support" (Interview 26, p. 4).

"The people I work with . . . are super. . . . If I'm supportive for them, they're supportive for me" (Interview 55, p. 14).

"I think we're pretty good here, . . . pretty good support systems for each other" (Interview 56, p. 5).

"Staff has to support you because you're so drained and they know you need moral support too. . . . They come by a lot and say you did a good job or it was a rough day . . . or whatever" (Interview 20, p. 11).

Nurses not only expressed connection toward babies and their parents, but also toward each other. Support for each other was especially critical when a baby the nurse was attached to was not doing well.

Appreciation of Differences

Although not as pervasive as other aspects of care, an appreciation of differences between people was apparent. The nurses attempted to understand others' ways of doing things,

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feelings and thoughts. This was directed toward the families because of the newborn's level of development. The following excerpt serves as an example:

"I think I covered all bases. I looked for . . . where the family was coming from" (Interview 55, p. 6). [This nurse goes on to describe her attempt to gain an understanding of the parent's religion, what this particular baby meant to them, and their previous experience with the health care system.]

It is difficult to take quotes illustrating this aspect of care out of context, because they often were quite specific to a particular baby. Yet, other nurses discussed similar issues. One described her concern about caring for a handicapped baby at home. Another nurse expressed her attempt, but subsequent inability, to understand parents who were Jehovah's Witnesses and refused to allow their daughter to have a blood transfusion when she obviously would have benefited from it. Care for these nurses involved appreciation of and an attempt to understand what it was like to be someone else.

Care of Self

The final category of care identified was care of self. The neonatal intensive care nurses described how they were able to continue working in the unit despite the heavy emotional toll. Listen to how the following nurses described care for self.

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> I try to . . . not take it home with me. . . . When I go home I have to try and turn it off because I have so many things going on at home. . . . You can only take so much . . . and then you have to leave it. . . . You become that involved. It's almost your own child. You can't have your own child dying every year (Interview 20, pp. 4-5).
>
> Sometimes you have to be detached from an infant in order to provide care because a lot of what we do is painful to the infant. You have to start IV's on them. You have to draw blood. You have to force their little limbs in certain positions just so they don't pull out the IV's. When they're crying you may not be able to feed them for some reason. . . . You have to stay detached. Otherwise you become so depressed because you're actually inflicting pain on these little people (Interview 13, p. 10).

"Sometimes detachment is probably better. You can't take every death personally"(Interview 34, p. 9).

In order to continue working in the unit, these nurses felt the need to detach or separate from the babies to some extent. They cared deeply but had to limit emotional involvement to protect themselves. As stated above, "You can't have your own child die every year" (Interview 20, p. 5).

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Other nurses cared for themselves by taking much personal pride in the quality of their nursing care. Listen to these examples:

"People that I know outside of hospital were questioning what I was doing. It was kind of personal pride. . . . I'll do the very best I can" (Interview 21, p. 2).

"I guess your pride is kind of at stake. If you can tell them that you did a really good job and if they know you did a really good job, that's really important" (Interview 26, p. 7).

"I did the best that I could for her. I tried to be the best nurse that I could be. I made a care plan out right away. . . and I signed up to be her primary nurse" (Interview 30, p. 5).

These interviewees found comfort in doing their very best as they cared for the babies. Knowing that they were giving good nursing care made it easier to handle the stresses of their jobs. They believed no one was capable of doing any more.

## Relationship to Brown's Taxonomy

The categories of care identified were strikingly similar to those identified by Brown (1989) when she interviewed adolescent girls ages 7-16 years. As listed in Table 2, the categories identified in this study that were similar to Brown's included not hurting, welfare of others, attachment and connection, appreciation of differences, and care of self. Terminology

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varied from Brown's for attachment and connection and appreciation of differences.

Table 2

Relationship Between Care Taxonomies

| Brown's Taxonomy | Chally's Taxonomy |
|---|---|
| Not hurting | Not hurting |
| Welfare of others | Welfare of others |
| Attachment/detachment | Attachment and connection |
| Difference/perspective | Appreciation of differences |
| Care of self | Care of self |
| Inclusion | |
| Interdependence | |

This researcher chose the terminology attachment and connection instead of attachment and detachment for a number of reasons: 1) Neonatal intensive care nurses described detachment from the babies as a method of caring for themselves. To detach was an important way of coping with the stress of their jobs. 2) Attachment seemed to be an appropriate concept to describe a relationship between a primary care giver and an infant. As discussed earlier, attachment describes a relationship between two or more persons based on love and

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acceptance. Yet the concept seemed less fitting to describe a relationship between nurses and parents or nurses and nurse colleagues. 3) Connection suggests a relationship of response based on the needs of others (Lyons, 1983). This term described more specifically the relationship between parents and nurse as well as among nurses.

Appreciation of differences seemed an appropriate category of care behavior in this study because nurses described their attempt to understand others' ways of doing things, no matter how different this was from the nurse's personal perspective. The term, appreciation of differences, more specifically described these care concerns and seemed clearer than difference/ perspective.

Referring again to Table 2, Brown's (1989) category of care entitled inclusion was not identified by this researcher. Inclusion, defined as the desire for solutions to conflicts to include all involved, was not a theme in the interviews with neonatal intensive care nurses. The researcher speculated that nurses discussing a professional dilemma were extremely well aware of the importance of including everyone involved in the decision making process. Interestingly, one way this concept was discussed was in the opposite sense. It was suggested that at times parents and even nurses who are extremely attached to the babies they are caring for cannot make objective decisions

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about what is best for the baby. Nurses also expressed that roles, a category in the justice taxonomy, may result in inequality between health care personnel. (See discussion concerning justice taxonomy.)

The researcher chose not to separate interdependence as a distinct category as had Brown (1989). Interdependence was defined as a "focus on the nature of connections between people" (Brown, 1989, p. 38). This interdependence seemed to be subsumed in all categories of care. The nurses who spoke of not wanting to hurt an infant did so because they were often affected by the pain they inflicted. Interviewee 21 said, "It's like I'm doing it to myself" (p. 3). Discussions about the baby's or parent's welfare centered on interdependence between the care giver and ones cared for. The category attachment and connection, even includes the key word, connection, of Brown's interdependence definition. The nurse can only appreciate differences if one realizes connections between others. Appreciating the importance of caring for self is to recognize that one can be more helpful to others if one is adequately cared for. This further reinforces the interdependence between people. Care, in and of itself, is based on an interdependence among people.

Relationship to Gilligan's Developmental Sequence

As discussed in the theoretical framework in Chapter 1, Gilligan (1977) described a developmental sequence of moral

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development from the care perspective. Level 1, identified as an orientation to individual survival, stressed the preservation of oneself as the primary concern. The nurses interviewed in this sample were not threatened by a loss of self. Their professional relationships could not diminish their survival. This phase of Gilligan's developmental model was not addressed by the nurses interviewed.

The second level of development identified by Gilligan (1977) was goodness as self sacrifice. At this point, the emergence of the traditional feminine voice was apparent and worth was based on caring for and protecting others. As was evident throughout the examples of care in the interviews, the nurses gave many illustrations of caring for others. In fact, all of the categories of care, except caring for self, fall into this level. This includes not hurting, welfare of others, attachment and connection, and appreciation of differences. This level was integral to care as discussed by neonatal intensive care nurses.

Gilligan's (1977) third level was entitled the morality of nonviolence. Inherent in this level was moral equality between self and others, thus allowing the assumption of responsibility for choice. Care for self clearly falls into this level. Nurses described taking pride in their professional work as one aspect of care for self. It was important that the quality of nursing care provided to babies be recognized. Nurses also described the

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detachment they imposed on relationships with babies in order to protect themselves from intense emotional upheaval. This was illustrated most clearly during Interview 20 when the nurse said, "You can't have your own child dying every year" (p. 5).

This study gave credence to two of Gilligan's (1977) developmental levels: goodness as self sacrifice and the morality of nonviolence. The preponderance of care categories which collapsed into the goodness as self sacrifice level suggest that this level needs further development and categorization. Brown's (1989) study of the development of a care voice in girls from 7 to 16 years of age attempted to address this criticism. Her end product, as referred to frequently in analyzing this first research question, was a taxonomy of care which included seven categories described from the perspective of a predominantly white, upper-middle class girls in four age groups: 7-8, 10-11, 12-13, and 15-16. Additional work still seems necessary in understanding the adult care voice. This researcher does not agree that all aspects of goodness result in self sacrifice. For example, one can decrease pain inflicted on a sick neonate without incurring a loss of oneself. The nurse must merely stop the painful procedure or give adequate pain medication. In the professional setting at least, goodness can be expressed toward others without self-sacrificing.

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## Summary

Caring is considered to be a universal phenomenon in nursing (Leininger, 1984). The nature of nursing requires and reinforces caring. Care is a central concept in nursing curricula (Fry, 1988). Human care theories are also developing within nursing (Leininger, 1984; Watson, 1985). In addition, theories in ethics are developing that have focused on the relationship of care to other moral principles or the justification of decisions based on care (Noddings, 1984). All of these have contributed to the moral and theoretical foundation of care's primacy (Benner & Wrubel, 1989) within the profession of nursing. This research determined that nurses use a perspective of care as a basis of decision making when faced with a moral dilemma. All nurses articulated a care perspective when discussing a moral dilemma. Seventeen of the 23 nurses interviewed identified care as the predominant approach for decision making. This further substantiates the nursing experience of caring. As Cooper (1989) identified, however, caring and Gilligan's (1987) work do not constitute a moral theory or provide guidelines for the nurse's moral action. Caring does, however, suggest a moral vision that is "compatible with nursing's long-standing historical and philosophical assumptions of relational caring. . . . Furthermore, it affirms the nursing experience of caring as a moral experience" (p. 10).

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Question Two

To what extent is a justice perspective used by registered nurses as they make moral decisions?

The justice perspective was used far less often than the care perspective when moral decisions were made by neonatal intensive care nurses. Only in three interviews (12%) was a moral decision made by aligning the self with justice. However, all nurses interviewed articulated at least an understanding of the perspective. The following describes an identified justice taxonomy.

Justice Taxonomy

Legal Issues

Some nurses described a justice perspective as they referred to the legal issues of a moral dilemma. Note the following examples:

"I feel like the parents would of had a good case, a good lawsuit if they [the physicians] had pulled the kid off the ventilator" (Interview 13, p. 4).

"I guess he [the physician] kept her on the ventilator and everything, but legally he had to" (Interview 30, p. 5).

"Well legally there was a lot at stake" (Interview 31, p. 3).

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"I don't want the parents to say that no one ever informed me and I'll see you in court. . . . You're always afraid of legality" (Interview 55, p. 9).

In these examples, the nurses realized that the court system may be pulled in and an enforceable legal answer to the ethical dilemma may result. According to Kohlberg's (1978) moral stages these nurses understand the law and order orientation of stage 4 when right behavior is determined by fixed rules and maintenance of social order.

Rights

Numerous nurses described the justice orientation for moral decision making from the perspective of rights. They believed rights were due individuals as members of our society. Examples include:

> She is going to be a complete vegetable her whole life. I didn't think it was right and I think that if the parents wanted to do that they should of had the right to do it when they wanted to (Interview 22, p. 5).

"My feelings are if you're going to be so big on pro-choice, saving all these children, then they should have the right to funding and facilities to help these people amount to something" (Interview 11, p. 8).

"This is a human being here who also has a right to die, a right to peace" (Interview 51, p. 3).

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Rights were due the babies as members of our society. In some situations the nurses felt the babies had a right to live and not be removed from life support. In addition they should be allowed to become all they could be. In other circumstances the nurses believed in the right of the baby to die peacefully and with dignity. Rights are similar to laws and rules, in that making moral decisions based on a person's rights designates a person in Kohlberg's (1978) fourth moral stage.

Rules

There were times nurses indicated they coped with moral dilemmas by following orders or protocols and not thinking about the situation. The following are examples:

"I decided to shut my mind off and do what I was supposed to do. . . . I felt that's my job and I know how to do it. I'll just do what I'm supposed to do" (Interview 21, p. 2).

> This is the protocol. This is what you do if the baby arrests. You start CPR. You start giving the meds. . . . You follow the steps that are appropriate and it's up to the attending . . . to say that's it, no more (Interview 25, p. 6).

"Just do what you have to do and try not to think about it" (Interview 26, p. 5).

Nurses also talked about following self imposed rules that were much more general than orders or protocols. For example:

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> It's the baby. It's a human life and that is what we're here for. I mean everybody up here is for the same purpose, and that's to save the child and to turn out a child that is as healthy and as normal as possible (Interview 25, p. 4).

"But I always try and side for life and that's just where I stand. . . . Once you choose to . . . resuscitate, you're responsible for the consequences" (Interview 30, p. 6).

When rules were in place there was no need to think beyond the prescribed standard. The rules could be followed to the letter. At times they were self imposed rules, for example, like always siding for life. At other times the rules were determined by hospital procedures. Regardless of the rules' origination, they determined what the nurses should do. Following rules is also a part of Kohlberg's (1978) fourth moral stage.

Obligations and Commitments

The understanding of justice as obligations and commitments was described when discussing physicians' understanding of dilemmas. Doctors were obligated to cure as in the following:

"It's very hard because doctors have this whole attitude. They don't want to give up. They want to cure. They want to fix. They want to make it better. They don't want to say I can't do anything else" (Interview 56, p. 4).

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"I guess on a purely medical sense you could look at . . . the facts and forget about the baby as a person" (Interview 32, p. 9).

Another aspect of this justice perspective related to the fact that the unit was located in a teaching hospital where residents needed to learn certain procedures and techniques. A commitment to education was a problem in some situations.

"Sometimes I feel like they're just trying things . . . to learn. I know there is a need for that. It's a teaching hospital . . . [but] the residents don't have the expertise" (Interview 56, p. 1).

"But there are times when . . . the residents want to do this and do that, and you think oh why, why, why? Are we practicing? Is that what we're doing?" (Interview 26, p. 2).

The category of obligations and commitments was identified as nurses discussed physicians' behaviors. The interviewees related that doctors were committed to curing patients, and as a result it was very difficult for them to acknowledge that nothing more could be done. In addition, in a teaching hospital residents have the need to gain expertise in procedures and techniques. This commitment to education conflicted at times with the nurses' concern about hurting the babies.

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Societal Concerns

Five nurses in the sample, when questioned about all they had considered in dealing with the dilemmas, voluntarily described concerns about our society in general. Their comments included:

> The bill was passed [that] in order to get state funding you had to resuscitate anything over 500 grams. Well that's ludicrous! . . . We're creating more of them yet the government is cutting back on everything to help them. . . . My feelings are if you're going to be so big on pro-choice, saving all these children, then you should have funding and facilities to help these people amount to something (Interview 11, pp. 4 & 8).
>
> I am sad and sorry for . . . our . . . . health system because we are all here for the same thing, to support life, but what did we do? . . . Somebody is drowning. We . . . help them out to the bank and then left [sic] them down there to die anyway (Interview 27, p. 7).
>
> The fact that the taxpayers are paying for all of this because they're probably on welfare. . . . I think with the elderly it's a lot easier because you know that they're going to die soon anyway and it's a short period of time that they're looking at living. . . . I think that decision is so much easier than with these premature babies. They have an

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entire life time ahead of them and they can live for years and years, whatever way they end up (Interview 30, p. 8).

"Reagan made a law that you have to save all these kids, . . . but the . . . federal funding . . . is just not there for programs to give these kids what they need to be at least productive individuals" (Interview 25, p. 10).

The last nurse who discussed justice from the category of societal concerns, was troubled over specific issues at her institution including the nursing shortage and what the institution might do to meet the chronic needs of infants who were comprised at birth but survived. She continued with, "We, . . . meaning society around us, are going to end up picking up the bill . . . and supporting him [a compromised infant] though adulthood" (Interview 10, p. 9).

These five nurses' perspectives, seem significant in deference to Kohlberg's (1971, 1978) moral stages. The interviewees suggested that standards used to make decisions concerning high risk neonates have not been agreed upon as "right" by all of society. Laws may need to be altered because of social necessities. Stage 5 of Kohlberg's (1978) theory describes moral decision making from a similar perspective.

Roles

A very common theme throughout the interviews was role inequality between the nurses and doctors. Nurses described role

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constraints as a result of this inequality that was quite distressing at times.

> I had been assigned first admit. When a baby is like a fetus and not viable this [pointing to a specific area] used to be transitional in here and they would carry the fetus from labor and delivery and just put them in here. We just took vitals until they died. So that's what they did. Then the one doctor said, 'Yes, this baby is not viable and then a few minutes later another doctor examined him and said this baby is viable and so they ran him into I.T. [the intensive unit] and they started resuscitating and doing all this stuff. At that point that was kind of ridiculous because the kid was already freezing cold and had been bradycardic and everything. . . . I didn't feel confident enough in myself to really say anything one way or the other, so I didn't. I just did what they told me (Interview 31, pp. 1-2).
>
> We [the nurses] have no say though. All we could do is sit there and say 'Come on you guys! What . . . are you doing? Look at this baby. ' . . . A lot of attendings . . . will agree with you, but they've already started. That's the whole thing (Interview 11, p. 5).
>
> I guess I felt like this is just one more experiment to see what we can do. It's definitely how it makes me feel. Let's see how young we can save them. . . . This is just so sick.

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> What are we doing here? I was mad. Why are they [the doctors] doing this? The little baby is going through pain. Just what are we doing it for? I felt like this was an experiment (Interview 21, p. 2).
>
> They [the doctors] already had a preconceived idea that this baby isn't going to survive. The rest of the nurses felt that we were supposed to treat clinically what we saw. We saw that the baby was driving to survive . . . and had a good cry and good heart rate. . . . We should treat the baby and give the baby a chance. On the other hand the physician thought this baby was going to die. . . . I had a very hard time with that, feeling that this baby had too many signs of trying to live. You really had to give the baby an option (Interview 57, p. 2).

Many additional examples could be cited expressing frustration by nurses that they were in a subordinate position in regards to actually making decisions about the babies they cared for. In numerous instances, the nurse was able to document why she had more information than the physician who actually made the decision. This is not justice as defined earlier in this study as equality, but lack of justice or equality between the nurse and physician. The struggle of the nursing profession to be more than a handmaiden in carrying out physicians' orders has been an

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issue since the time of Florence Nightengale. It continues with these nurses in neonatal intensive care.

Relationship to Rogers and Gilligan's Themes

Rogers and Gilligan (1988) identified eight themes of the justice voice when 112 7th and 10th grade girls from a private school were asked to fill out the Washington University Sentence Completion Test (Loevinger & Wessler, 1970). Unfortunately, these themes are not defined, but only listed with examples given from the literature and the sentence completion test. As a result the precise meaning of each category remains open for individual interpretation.

Table 3 depicts the relationship between Rogers and Gilligan's (1988) themes and those identified by this researcher. The limited number of nurses who made moral decisions from a justice perspective in this study may account for the discrepancy between the responses in this study and the larger number of categories identified by Rogers and Gilligan.

Three of the categories did not appear appropriate perspectives as professional nurses discuss ethical dilemmas however. It is very possible that nurses do not see themselves as separate, independent or autonomous in the clinical setting and as a result would not discuss that aspect of justice as did interviewees in Rogers and Gilligan's (1988) sample. Empathy as role taking was identified by Rogers and Gilligan as an extremely

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rare way of using a justice perspective. In their research, four responses in total were classified in this category. Those responses depicted a reciprocity between two people as a trade off to meet another's need. Such an approach, (i.e., "I'll scratch your back if you'll scratch mine."), seems more common in personal relationships and less suitable when caring for ill neonates. In addition, concern for personal freedom, choice or self-fulfillment (the eight category) seems to be an inappropriate topic to discuss when describing ethical dilemmas regarding life and death issues of someone else's sick child. It may have been described if nurses were asked about ethical dilemmas involving their career or personal aspirations.

This researcher intentionally used different terminology to name the categories of justice than had Rogers and Gilligan (1988). It was felt that shorter category titles were less wieldy. In addition, the words chosen more specifically described the actual justice classification being discussed by the nurses interviewed. For example, rules is a part of two of Rogers and Gilligan's categories. Societal concerns was chosen to represent those issues that involve more than just a specific set of circumstances, but an overriding concern for all babies in comparable situations. This titling seems comparable to concern for fairness, justice, equality and freedom from oppression.

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Table 3

Relationship Between Justice Taxonomies

| Rogers and Gilligan's Taxonomy | Chally's Taxonomy |
|---|---|
| Relationships mediated through rights, rules, limits or standards | Legal issues<br>Rights |
| Concern with rules, beliefs, and self-chosen principles | Rules |
| Responsibilities to duties, obligations, and commitments | Obligations and commitments |
| Concern for fairness, justice, equality, and freedom from oppression | Societal concerns |
| Roles, role expectations | Roles |
| Concern for separation, independence, autonomy or individuality | |
| Empathy as role-taking or reciprocity | |
| Concern with personal freedom, choice, ambition, and self-fulfillment | |

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## Relationship to Kohlberg's Moral Stages

As discussed in the theoretical framework in Chapter 1, Kohlberg (1971, 1973, 1976, 1978) described six moral stages through which people developmentally progress. As nurses discussed moral dilemmas from a justice perspective in this research they validated the existence of three of these stages.

Nurses whose moral decisions resulted from role inequality exhibited characteristics of Kohlberg's (1976, 1978) third stage entitled mutual morality. These nurses conformed (or were forced to conform) to stereotypical images of what was sanctioned as natural behavior by the majority of nurses and physicians. The nurses frequently expressed frustration, however, at the limitations of decision making based on this perspective. It allowed the nurse a role in the solution of an ethical dilemma only through scheming or game playing. Living up to what was expected by the nurse was to follow doctors' orders. Such a perspective was very limiting to nurses who could often document how their determinations were based on more accurate criteria than physicians' deliberations.

Nurses whose justice perspective was based on legal issues, rights, rules, or obligations and commitments conform to Kohlberg's (1976, 1978) fourth stage, social system morality. Social system morality is a law and order orientation where there is maintenance of order by laws, rules, rights, and commitments.

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Right behavior consists of maintaining social order by fulfilling agreed upon social duties. It was important to nurses whose moral decisions resulted from these categories to keep the system going by meeting defined social obligations. Such duties were shared and accepted by the community. Laws are voted into existence and rights are part of the United States Constitution. Protocols and procedures are agreed upon by clinicians. Obligations to work in a teaching hospital are agreed upon with acceptance of a position. Since four of the six justice categories collapse into this particular Kohlbergian stage, it presented as the most predominant moral development stage from which nurses functioned in the justice perspective.

Finally, five of the nurses discussed issues from a societal perspective. This corresponds to Kohlberg's (1976, 1978) fifth stage of social contract morality. As Kohlberg defined this stage, right is a matter of personal values and opinions resulting in special attention given to the legal point of view. The nurses realized, however, that laws and commitments could be changed with rational consideration of what constituted the greatest good for the greatest number. Some of those nurses interviewed had more rational suggestions for revising laws than other nurses. Yet, their comments indicate a concern on their part for social change.

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## Summary

Justice renders unto others what is their due. Equals must be treated equally and unequals treated unequally (Beauchamp, 1982). The paradigm case of injustice results when there are similar individuals in identical circumstances and one of them is treated better or worse than the other one. The principle of justice is limiting, however, because it does not specify: a) who is equal and unequal, and b) what the morally acceptable differences among persons that allow one to determine what each is due (Silva, 1990). All nurses understood justice as a moral perspective. Only three made moral decisions from that perspective, however. This fact suggests, that for nurses, another perspective is more useful or relevant.

### Question Three

To what extent do registered nurses combine the justice and care perspective as they make moral decisions?

Even though all nurses articulated an understanding of both the care and justice perspective, six nurses combined the two viewpoints as decisions concerning moral dilemmas were being deliberated. Four nurses identified as combining perspectives did so by incorporating care and justice in a single passage. Note the following examples where justice and care are interwoven.

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Examples of Care/Justice Perspective

> I don't think she's ever going to be able to do anything and it's just going to be so hard on her parents. I don't think it's fair because she's going to suffer her whole life. . . . I didn't think it was right and I think that if the parents wanted to do that they should have had the right to do it when they wanted to (Interview 22, p. 5).

This nurse began by expressing concern for the baby and the baby's parents. She then talked about what was fair but indicated concern for the baby's suffering. She continued by discussing the parents' rights, indicating that the parents should have been allowed to make their own decision concerning their daughter's welfare. In this passage one first hears first care, then justice, then care again, and finally justice.

> I decided to shut my mind off and do what I was supposed to do. . . . I felt that's my job and I know how to do it. I'll just do what I'm supposed to do. I'll do the very best I can and then I really got involved with her. I really loved her and I wanted her to pull through! . . . Then I had to go away on my honeymoon in the middle of it and I didn't want to leave. Once you decide you're going to go along with the plan, then you really try to get involved and agree with what you're doing (Interview 21, p. 2).

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Certainly shutting off one's mind is a description of objectively following protocol, but this nurse was only able to do so for a brief while. Very soon she fell in love with the baby. The reader may be relieved to know that the interviewee did go on her honeymoon. She continued to say that the baby, although discharged, remains a definite part of her life. The baby is in her photo album and she still thinks of her often.

Interview 10 has previously been quoted at some length because of the nurse's societal concerns. She also combined perspectives in deliberating an ethical dilemma.

> How far should I as a person who is involved with this kid, who loves this kid, call it what it is, . . . interfere in this? I'm not a member of their staff. . . . I want to see this kid get the best care possible. I have a real need for that personally, but on the other hand, I don't want to interfere in the care that he's receiving down there [meaning the pediatric intensive care unit] (Interview 10, p. 3).

This nurse was very attached to a baby she had been the primary nurse for. The baby was discharged and then later readmitted to the pediatric intensive care unit of the same institution. The nurse was aware of the depth of her feelings for him, but at the same time determined politically that it was important that the appropriate protocol be followed and the right people approached with her concerns.

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> You think about the family because we all knew it [the baby] had been here for a while. They are losing the baby suddenly. . . . Did we make the right choice? But then you also have a thought that this is the protocol. This is what you do if the baby arrests. You start CPR. You start giving the meds that you need to give. . . . You follow the steps that are appropriate (Interview 25, p. 6).

The interviewee began by expressing concern about the family. Although the concern in this passage was real, one hears much more care for families in subsequent passages. As an example she said later on, "It's like I'm giving up. This is somebody's child here and how can you let go of that when there is still a chance? How are you going to tell them? . . . How are they going to feel down the road?" (p. 7-8). Through a web of connection, she thought about the family and how devastated they would be with the loss of their daughter. At the same time the nurse realized the severity of the baby's medical problems and was afraid that she would never be able to function as a normal little girl. Instead, hers would be a life of continual battles and handicaps. In the next breath the nurse seems to switch her mode of thinking to justice. She suddenly says, "This is the protocol" (p. 6). At that point she acts by giving another round of drugs and initiating other appropriate lifesaving steps. The

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baby survived and eventually went home. Definitely care and justice were interwoven in this example.

Two nurses who articulated both a care and justice perspective did so by interweaving both care and justice throughout the entire interview. They articulated awareness of contradictions and paradoxes that could only result from using both perspectives.

The following quotes characterized a justice perspective:

"I always know for me what I feel is the right thing to do" (Interview 52, p. 1).

"We did the meds. . . . We put chest tubes in and we re-intubated the baby. We did everything according to protocol . . ." (Interview 52, p. 9).

"Of course I didn't just not tell anybody what happened. . . . I went to management and I was like this is ridiculous" (Interview 52, p. 11).

The following examples come from a care perspective:

"We do get attached to them especially when they're around here for so long and they're so sick and you go through so much with them" (Interview 52, p. 8).

"I feel very strongly that the baby had been through enough physical pain and that the baby did not have a chance of having a normal life. The baby didn't have a family that cared about him" (Interview 52, p. 10).

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Because of the expression and understanding of care and justice throughout the narrative, this nurse identified alternatives to the moral problem that would have been lost with the use of just one perspective. Similar examples of care and justice are obvious in Interview 30 also and have been previously quoted in response to research questions one and two.

Relationship to Gilligan's Work

Gilligan (1987) suggested that justice and care are not opposites of one another, but represent very different ways of organizing moral decision making. The organizing dimension of the care relationship is attachment/detachment. From a justice perspective, one organizes interactions through equality/inequality. To organize relationships in terms of attachment is to do so through the metaphor of a network or web. This is very different than a justice perspective where relationships are perceived as a hierarchy. From the care perspective, the self responds to needs and questions how best to reply. The self from the justice perspective strives to maintain a standard of equality or commensurate respect.

Gilligan and Attanucci (1988) identified a care/justice category when young adult and adolescent males and females were asked to describe a moral dilemma. These researchers determined that the care/justice category was equally divided between men

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and women. Both care and justice considerations were introduced into the same reasoning episode in their sample.

Gilligan (1987) suggested that an ambiguous figure perception was useful to illustrate changes in perspectives. The ambiguous figure suggests that one can see a moral dilemma in more than one way, and that one may even alternate ways of viewing the figure. In addition, the gestalt figure is illuminating because it suggests that some people have trouble seeing more than one image in a gestalt illusion (Flanagan & Jackson, 1987). A change in perspective thus alters perception and understanding. Looking through different lenses is another metaphor to describe changes in perceptions (Brown, 1988). Through one lens, only small details are visible. Through another lens the entire picture comes into focus.

Brown (1988), a student of Gilligan, expressed that a justice and care perspective could be integrated throughout the interview and neither actually predominate. She differentiated integration on what she termed the "micro" level (perspectives combined within a single text of the interview) versus integration on the "macro" level (perspective combined throughout the entire interview.) In this research, examples have been cited from both the "micro" and "macro" levels.

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## Summary

Much more remains to be learned about people who deliberate from a combined care/justice perspective. In this study, 23% of neonatal intensive care nurses interviewed spoke of care and justice in such an integrated manner that neither perspective could be designated as predominant. Are these the nurses whose moral practice is to be most admired? Are they the ones who, because of integrating both perspectives, can determine approaches to dilemmas that are not obvious from either perspective singularly? Indeed, this group must be studied further.

### Questions Four

Can any additional perspectives be identified that do not clearly fit into the care or justice perspective?

The researcher was unable to identify any additional perspectives that did not clearly fit into the care or justice perspective. This conclusion was reached only after much analysis of the interviews and discussion with other published authors in the area of moral development (Brown, 1989; Cassidy & Oddi, 1988; Cooper, 1989).

During the first analysis of the interviews the researcher read all interviews five times, as described in Chapter III, to determine if the interviewee described a care, justice, combined and/or any additional perspective. Any perspective that did not

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seem to clearly fit into a care or justice category was identified. About half way through the analysis, one category of responses seemed to present itself. Nurses talked about wanting to do their best for the babies they were caring for. The following quotes are illustrative:

> I feel overall that the underlying line usually is wanting to do what is best for the baby--whatever you can do to give the baby the best chance to survive, and to survive at the highest level that is possible for the baby (Interview 57, p. 5).

"You try to do the best you can. . . . It was kind of a personal pride" (Interview 21, p. 2).

"I did the best that I could for her. I tried to be the best nurse that I could be" (Interview 30, p. 5).

To the researcher, this sounded much like the ethical principal of beneficence. Flynn (1987) indicated that beneficence includes four duties: a) not to inflict harm or evil, b) to prevent harm or evil, c) to remove harm or evil, and d) to promote or do good. It was the concern about not inflicting harm, already identified as a component of care entitled not hurting, and doing good that struck the researcher as a component of decision making with neonatal intensive care nurses. After the original interview analysis, the researcher subsequently went back and re-read the interviews. The

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perspective of beneficence was apparent. The nurses indicated a desire to not inflict harm and promote as much good for the babies as possible.

Beneficence can be viewed as a component of care. In this context, the researcher has chosen to not single out beneficence as a separate perspective of moral decision making. This inclusion of beneficence as a component of care is in keeping with Brown (1989) who entitled one taxonomy of care as the welfare of others and another as not hurting. The welfare of others is defined as the "wish to protect those for whom self cares" (p. 190). Not hurting in Brown's taxonomy refers more to psychological interest, but nevertheless suggests concern about hurting others. Rogers and Gilligan (1988) also included helping, supporting or promoting the well-being of others as a theme of care, as well as paying attention to hurt, harm or suffering as an additional theme. The neonatal intensive care nurses described wanting to do as much good for the babies they cared for as possible in order to promote their well being and avoid inflicting pain or suffering.

Penticuff (1989) defined an ethic of good in neonatal intensive care "from the perspective of the infant's present and future experiences, within the context of the prerogatives of the infant's caring family" (p. 988). Two broad categories were identified as preliminary elements of an ethic of good. The

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categories included efforts to reduce discomfort or suffering and attempts to facilitate examination of whether continuing life-prolonging treatments were in the infant's best behalf. An ethic of good focused on what was good for individual families and infants. Unfortunately, Penticuff did not develop the concept of an ethic of good any further. This researcher recognizes the relationship between good as described by Penticuff and the care categories she identified in this study. Both include not hurting, attachment, and the welfare of others. Although Penticuff chose to use different terminology, the findings of this study and her research are interrelated.

Summary

This researcher was unable to identify any additional perspective of moral decision making other than care, justice and a combined care/justice approach. The broadness of justice as defined by Kohlberg (1971, 1976, 1978) and Rogers and Gilligan (1988) and care as defined by Gilligan (1977, 1982) and Brown (1989) are encompassing. The significance of beneficence in regards to a perspective of moral decision making remains open to interpretation, however.

Question Five

How do demographic variables relate to the perspective used by registered nurses to make moral decisions?

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Demographic data were collected from all nurses interviewed. Information collected included: age, race, marital status, presence and number of dependents, current religious affiliation, religion raised in, type of basic nursing education program, country in which received basic nursing education, highest academic credential held, year registered to practice professional nursing, number of years practiced as a professional nurse, number of years employed in current unit, number of years experience in neonatal intensive care, average number of hours employed per week, formal course work in bioethics, nursing issues or perspectives and/or neonatal nursing and continuing education or inservice in bioethics, nursing issues or perspectives and/or neonatal nursing. (See Appendix A.) All nurses interviewed were female and were directly involved in caring for babies. Head nurses or assistant head nurses were not interviewed. The homogeneity of the sample will become apparent as each category is discussed.

In addition, the demographic questionnaire inquired about the unit and hospital in which the nurses worked. Since all nurses interviewed were from the same institution, this information did not vary from nurse to nurse. It is interesting to note that some nurses did not give accurate information regarding the institution which employs them. The researcher assumes this was due to lack of knowledge on the nurses' part.

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assumes this was due to lack of knowledge on the nurses' part. Discrepancies between beliefs and reality will be discussed.

The hospital in which the nurses work is a private, for profit institution that is not affiliated with a religious organization. The hospital at one time was associated with the Presbyterian religious denomination and still retains the word "Presbyterian" in its title. No longer, however, is there a direct affiliation between the institution and the denomination. Yet, eight nurses (31%), believed the hospital remained affiliated with the Presbyterian denomination. It is also interesting to note that only 6 of the 26 nurses (23%) indicated the hospital was for profit. The remainder (67%) believed the hospital was not in the business of making money.

The hospital itself does not have an ethics committee. Nurses interviewed were very confused about this issue. Eleven (42%) nurses realized the institution did not have an ethics committee, ten (39%) thought there was such a committee and five (19%) were uncertain. The confusion seems to have resulted because the neonatal intensive care unit holds bimonthly ethics rounds for nurses, doctors and other health care personnel conducted by a theologian with an ethics background. During these rounds, which were attended by the researcher, a case review of concern to participants is discussed and options for dealing with the ethical situation are considered. The nurses

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may have been confused about the difference between these rounds held within the unit itself and an ethics committee which functions for the hospital as a whole. As discussed in the literature (Fowler & Levine-Ariff, 1987), either a hospital wide committee or a unit group can assume the functions of an ethics committee.

The unit utilizes primary nursing and all but five of the nurses interviewed (81%) functioned as a primary nurse. In fact, many of the ethical dilemmas discussed concerned a baby for whom the interviewee was a primary nurse. The usual patient to staff ratio varied 1:1 to 1:5 depending on the acuity of the babies cared for.

Age

The age range of the nurses varied from 23 to 51 years of age. As presented in Table 4, 14 or 54% of the nurses were between the ages of 23-29 years of age and 10 or 38% were from 30-39 years old. One nurse interviewed was 44 years old and one nurse was 51 years old. The mean age was 30.2 years. The median age was 28.5 years.

The relationship between age and moral voice predominance is presented in Table 5. It is interesting to note an increased use of the care perspective in nurses over age 25 years and a decrease in the use of a care/justice perspective in that same age group. Although numbers were not large, this began to

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suggest a developmental phenomenon concerning the perspective used by nurses when facing an ethical dilemma. Younger nurses were less likely to function from a care perspective. This will be discussed in greater depth when nursing experience and moral voice perspective are analyzed.

Table 4

Age in Years

| Years | Number |
|---|---|
| 23-25 | 7 |
| 26-29 | 7 |
| 30-34 | 6 |
| 35-39 | 4 |
| 40-49 | 1 |
| 50+ | 1 |
| Total | 26 |

Racial and Ethic Background

All but two of the nurses interviewed were white. The two non-white nurses both indicated they were of Asian descent. One, 25 years of age and a practicing Buddhist, received her basic nursing education in a baccalaureate program in the United States. The second Asian nurse, the oldest in the sample at 51

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years, received her basic nursing education in a baccalaureate program in the Philippines. This nurse talked at length during the interview about the significance of Catholicism in her nursing practice.

Table 5

Relationship Between Age and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Age in Years | No. | % | No. | % | No. | % | No. | % |
| 23-25 | 3 | 43 | 1 | 14 | 3 | 43 | 7 | 100 |
| 26-29 | 5 | 72 | 1 | 14 | 1 | 14 | 7 | 100 |
| 30-34 | 5 | 83 | | | 1 | 17 | 6 | 100 |
| 35-39 | 3 | 75 | | | 1 | 25 | 4 | 100 |
| 40-49 | | | 1 | 100 | | | 1 | 100 |
| 50+ | 1 | 100 | | | | | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Two non-white nurses are certainly a very small number and any comparisons for this group may be misleading. It is interesting to note, however, that the younger nurse used justice as a primary moral orientation. This nurse felt her job was "to

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be mostly objective" (Interview 23, p. 8). She also believed health care should follow rules. For example she stated, "If you're going to resuscitate the kid you do everything for the kid afterwards" (p. 5). The older nurse described a care perspective based on strong attachment to the baby and parents she cared for. This nurse also spoke globally about societal injustices, however. She said in speaking about the specific child involved in the dilemma, "I am sad and sorry for the child and of course our health system. . . . What did we do? . . . Somebody is drowning. We . . . help them out to the bank and then left [sic] them down there to die anyway" (Interview 27, p. 7). The child she is referring to was hospitalized for an extensive period of time after birth, and then died at home shortly after being discharged. It is important that nurses from racial and ethnic minorities be sought out to further understand their perspective when making moral decisions.

Marital Status

All nurses interviewed indicated their marital status. Eight (31%) of the 26 nurses were single, seventeen (65%) were married and 1 (4%) was divorced or separated. Table 6 shows the relationship between marital status and moral voice predominance.

The percentage of nurses using a specific moral voice predominance does not appear to vary much based on marital status. A care perspective was used by 62.5% of single women

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when describing a moral dilemma, as did 70% of married women. Use of justice or care/justice predominance also did not change much depending on if the nurse was married or single. Only one nurse was separated or divorced; therefore, it is unfair to suggest any trends in this category.

Table 6

Relationship Between Marital Status and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Marital Status | No. | % | No. | % | No. | % | No. | % |
| Single | 5 | 62.5 | 1 | 12.5 | 2 | 25 | 8 | 100 |
| Married | 12 | 70 | 1 | 6 | 4 | 24 | 17 | 100 |
| Separated/Divorced | 0 | 0 | 1 | 100 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Dependents

The relationship between the presence of dependents and moral voice predominance is depicted in Table 7. Eleven (42%) nurses interviewed indicated they had dependents. Nine of the 11 had children. Four nurses indicated they had other dependents. (Two of these four also had children.) The data indicated that

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presence or absence of dependents affected moral voice predominance very little. The greatest variation in percentage of moral voice predominance was in the care/justice group. Those figures were merely 7% different, however, and based on only three nurses with dependents and three without.

Table 7

Relationship Between Presence of Dependents and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Presence of Dependents | No. | % | No. | % | No. | % | No. | % |
| Yes | 7 | 64 | 1 | 9 | 3 | 27 | 11 | 100 |
| No | 10 | 67 | 2 | 13 | 3 | 20 | 15 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Since nurses when interviewed had indicated that parenting, or in some instances even the anticipation of parenting, affected their nursing care of babies in neonatal intensive care, the researcher thought it important to single out the relationship of having children to the predominance of moral voice. Table 8 shows that relationship. There was even less variation among the

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subgroups who were and were not parents, than among the subgroups who have or did not have dependents.

Table 8

Relationship Between Having Children and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Children | No. | % | No. | % | No. | % | No. | % |
| Yes | 6 | 67 | 1 | 11 | 2 | 22 | 9 | 100 |
| No | 11 | 65 | 2 | 12 | 4 | 23 | 17 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

It is of interest to acknowledge that only one nurse who had children described ethical decision making solely from the justice perspective. Yet in the sample interviewed, only 3 nurses used the justice perspective exclusively, so a trend certainly cannot be identified. The researcher can only speculate as to why differences in moral voice predominance are not greater depending on the presence or absence of children. The affect of parenting, as discussed by the nurses, may not be of enough significance that actual moral voice predominance varied. Also, not all parents discussed the affect of parenting

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on their neonatal intensive care nursing practice either. Most of the parents who brought up the issue of parenting volunteered that they were new mothers, (within 6 months - 2 years). Perhaps having recently had a baby is the key to parenting affecting nursing care. Once motherhood becomes "old hat," having one's own children may not make that much difference.

## Religion

The homogeneity of the sample was apparent regarding religion. Twenty (77%) of the nurses were currently affiliated with the Roman Catholic Church. Three (12%) indicated they were not affiliated with any religion, two (7%) stated they were Protestant and one (4%) nurse listed her religion as Buddhism.

Table 9 depicts the relationship between current religious affiliation and moral voice predominance. The predominant use of care was higher in Roman Catholics (75%) than in the sample population as a whole (65%). The two Protestant nurses both described dilemmas from a care/justice perspective and the one Buddhist nurses discussed a justice approach. The numbers of non-Catholic nurses were so small, however, that no definite trend can be determined.

Table 10 characterizes the relationship between the religion the nurses were raised in and moral voice predominance. Two fewer nurses were raised as Roman Catholics than are now practicing the religion. Eighteen (69%) were raised Roman

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Catholic, six (23%) were raised as Protestants, and two (8%) were not raised in any religion.

Table 9

Relationship Between Current Religious Affiliation and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Current Religion | No. | % | No. | % | No. | % | No. | % |
| Roman Catholic | 15 | 75 | 1 | 5 | 4 | 20 | 20 | 100 |
| None | 2 | 67 | 1 | 33 | 0 | 0 | 3 | 100 |
| Protestant | 0 | 0 | 0 | 0 | 2 | 100 | 2 | 100 |
| Buddhism | 0 | 0 | 1 | 100 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Roman Catholics continued to be more likely to use a care voice in deliberations of ethical dilemmas. Six nurses were raised as Protestants. Of those six nurses, one described a justice perspective and three a care/justice perspective. This was higher than the sample in general and included more nurses than those who are currently practicing Protestants. The apparent trend is interesting, although it can only be addressed

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Table 10

Relationship Between Religion Raised In and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Religion Raised | No. | % | No. | % | No. | % | No. | % |
| Roman Catholic | 14 | 78 | 1 | 5 | 3 | 17 | 18 | 100 |
| Protestant | 2 | 33 | 1 | 17 | 3 | 50 | 6 | 100 |
| None | 1 | 50 | 1 | 50 | 0 | 0 | 2 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

as preliminary and needing further study. Thirty-three percent of the Protestant nurses used care as compared to 65% in the total sample population. In addition, 50% of the Protestant nurses used a combined care/justice perspective as compared to 23% of the total sample. This seems even more important when coupled with the fact that all of the Protestant nurses (100%) currently affiliated with the religion (See Table 9) used a care/justice perspective.

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## Education

Table 11 relates moral voice predominance and basic nursing education preparation. All but three nurses in the sample received their basic nursing education in a baccalaureate degree program. Two nurses originally graduated from a diploma program. One of those nurses functioned from the care perspective and the other from a justice perspective. One nurse received her basic education in an associate degree program. That particular nurse functioned from a justice perspective. It may be of some importance that of the three nurses who functioned from a justice perspective when describing an ethical dilemma, two did not receive their education in a baccalaureate nursing program. Larger numbers of nurses whose basic preparation was at the diploma and associate degree level are necessary to substantiate findings.

Nurses were asked about the highest academic credential they presently hold. Table 12 shows the relationship between moral voice predominance and highest academic credential attained. Despite increased variance compared to the nurses' basic educational preparation, the small numbers of nurses who did not hold a baccalaureate degree in nursing as the highest degree attained make it impossible to suggest any definite trends. It is interesting to note, however, that 50% (1 in number) of the nurses who currently hold a diploma were identified as

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functioning from a justice perspective and 100% (2 in number) of the nurses holding a master's in nursing indicated a care/justice predominance.

Table 11

Relationship Between Basic Nursing Preparation and Moral Voice Predominance

| Basic Nursing Preparation | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| | No. | % | No. | % | No. | % | No. | % |
| Diploma | 1 | 50 | 1 | 50 | 0 | 0 | 2 | 100 |
| Associate | 0 | 0 | 1 | 100 | 0 | 0 | 1 | 100 |
| Baccalaureate | 16 | 70 | 1 | 4 | 6 | 26 | 23 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

The relationship between formal course work in bioethics, nursing issues, and neonatal nursing is shown in Table 13. These courses were specifically inquired about because the researcher believed study in any of these areas may be helpful to nurses as they dealt with ethical dilemmas in neonatal intensive care.

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Table 12

Relationship Between Highest Academic Credential Attained and Moral Voice Predominance

| Highest Academic Credential | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| | No. | % | No. | % | No. | % | No. | % |
| Diploma | 1 | 50 | 1 | 50 | 0 | 0 | 2 | 100 |
| Baccalaureate in Nursing | 13 | 72 | 1 | 6 | 4 | 22 | 18 | 100 |
| Baccalaureate in Other Field | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |
| Master's in Nursing | 0 | 0 | 0 | 0 | 2 | 100 | 2 | 100 |
| Master's in Other Field | 2 | 100 | 0 | 0 | 0 | 0 | 2 | 100 |
| Doctorate in Other Field | 0 | 0 | 1 | 100 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Just over half (14 or 54%) of the sample indicated they had taken a course on bioethics. The percentage is higher than the researcher expected. Nursing curricula are often packed full and bioethics is frequently viewed as an extra that is nice, but not required. It is encouraging to determine that 54% of nurses

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interviewed had the experience of being involved in such a course. Of those students who had a formal bioethics course, only one (7%) described ethical dilemmas from a justice perspective. This is 5% below the sample population. Four nurses (29%) functioned from a care/justice perspective. This is 6% higher than the sample as a whole.

Table 13

Relationship Between Formal Courses and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Formal Courses | No. | % | No. | % | No. | % | No. | % |
| Bioethics | 9 | 64 | 1 | 7 | 4 | 29 | 14 | 100 |
| Nursing issues | 8 | 57 | 1 | 7 | 5 | 36 | 14 | 100 |
| Neonatal nursing | 12 | 63 | 3 | 16 | 4 | 21 | 19 | 100 |
| None | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |

The same number of nurses (14 or 54%) indicated that they had a course in nursing issues as those who had a course in bioethics. This was surprising to the researcher since all but three of the nurses had a baccalaureate or higher degree in nursing. The inclusion of an issues course is generally accepted

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practice in most baccalaureate nursing programs. This should have been particularly true for these nurses since most had completed their nursing education fairly recently. It may be that the nurses do not remember the course or it is also possible that the programs attended by those interviewed in this sample did not include such an issues course. Table 13 also indicates the relationship between taking an issues course and moral voice predominance. Eight (57%) of nurses functioned from a care perspective after having completed such a course. This was 8% less than the sample population as a whole. One nurse (7%) made moral decisions from the justice perspective and 5 nurses (36%) deliberated from a combined perspective. The combined perspective is 13% higher than the sample population. With such small numbers no definite conclusions can be reached.

Nineteen nurses (88%) indicated that they had taken a formal course in neonatal nursing. This was a high percentage of nurses, but probably reflected the advanced preparation of the nurses and their interest in this area. Having taken a formal course in neonatal nursing made very little difference in regards to moral voice predominance.

Only one nurse indicated that she had not taken a course in bioethics, nursing issues, or neonatal nursing. This nurse described moral dilemmas from a care perspective.

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Interviewees were also questioned about the continuing education or inservice programs they had attended that may have affected decision making in neonatal intensive care. Programs asked about included nursing ethics, nursing issues, and neonatal nursing. Table 14 shows the relationship between continuing education or inservice programs and moral voice predominance.

Table 14

Relationship Between Continuing Education or Inservice Programs and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Continuing Education | No. | % | No. | % | No. | % | No. | % |
| Nursing ethics | 6 | 50 | 2 | 7 | 4 | 33 | 12 | 100 |
| Nursing issues | 5 | 41.5 | 2 | 17 | 5 | 41.5 | 12 | 100 |
| Neonatal nursing | 15 | 65 | 3 | 13 | 5 | 22 | 23 | 100 |
| None | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |

Twelve nurses (46%) had participated in a program on nursing ethics. Of those 12 nurses, 6 (50%) functioned from a care perspective. This was 15% lower than the sample population as a whole. Two (17%) described the dilemma from a justice perspective and four (33%) discussed a combined perspective. The

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combined perspective was 10% higher than the sample population. In this sample, attending a course on nursing ethics was related to an increased care/justice moral voice predominance and a decreased care moral voice predominance. This finding seemed to reinforce that much of nursing ethics does not come from a care perspective, but is based on Kohlbergian justice theory or normative ethics.

Twelve nurses had also attended a continuing education or inservice class on nursing issues. Only five nurses (41.5%) described an ethical dilemma from a care perspective if they had attended such a program. This number is 23.5% lower than the nurses in the entire sample who functioned from a care perspective. Nursing ethics is often included as part of nursing issues and this finding may further reinforce that much of nursing ethics is based on normative ethics or Kohlbergian justice theory base. However, without further study one cannot conclude that nursing issues programs include a preponderance of information on nursing ethics. The number of nurses who described a moral dilemma from a care/justice perspective and attended a program on nursing issues was very high in comparison to the sample population. Although it involved only five nurses, that accounted for 41.5% of all nurses who had participated in a nursing issues program. This is 18.5% higher than the sample population. The researcher cannot identify any other reason why

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a continuing education or inservice program on such a topic would affect moral predominance in this manner. Further study is definitely warranted.

As with formal course work in neonatal nursing, the relationship between attendance at continuing education or inservice programs in this area and moral voice predominance did not vary from the sample as a whole. As expected, a large percentage of nurses (88%) indicated that they had attended programs on neonatal nursing.

Again only one nurse related that she had not attended any continuing education or inservice programs on any of the specified topics. This was a different nurse than the one who had no formal course work in the areas inquired about but she also described ethical dilemmas from a care perspective.

Experience

Tables 15-18 show the relationship between years licensed as a registered nurse, years spent in nursing, years practicing in neonatal nursing, and years employed in this particular unit and moral voice predominance. Findings were suggestive of a developmental process through which new graduates progress as they develop into experienced professional nurses.

Table 15 depicts the connection between years licensed as a registered nurse and moral voice predominance. Nurses who have practiced ten years or less were less likely to describe a moral

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dilemma from a care perspective. Nurses who have practiced 1-5 years were more apt to discuss such a dilemma from a care/justice predominance than the sample population in general. Nurses who have been licensed from 11-15 years used care more often than the sample population, but only three nurses interviewed had been licensed as a registered nurse for this length of time. All three of the nurses who had been licensed for over 16 years functioned from a care perspective.

Table 15

Relationship Between Years Licensed as a Registered Nurse and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Years Licensed | No. | % | No. | % | No. | % | No. | % |
| 1-5 | 7 | 58.3 | 1 | 8.3 | 4 | 33.3 | 12 | 100 |
| 6-10 | 4 | 57 | 2 | 29 | 1 | 14 | 7 | 100 |
| 11-15 | 3 | 75 | 0 | 0 | 1 | 25 | 4 | 100 |
| 16-20 | 2 | 100 | 0 | 0 | 0 | 0 | 2 | 100 |
| Over 20 | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

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Table 16 addresses the relationship between the number of years the nurse had actually practiced as a registered nurse and moral voice predominance. As expected, the findings were very similar to those depicting the relationship between years licensed and moral perspective. The only difference in Table 16 in comparison to Table 15 was that one nurse who had been licensed for 11-15 years had only practiced for 6-10 years. As a result, since she was identified as making moral decisions from a care perspective, the percentages of nurses practicing from 6-10 years more closely resembled the sample population as a whole. Nurses who have practiced for 1-5 years were slightly less likely to discuss a care perspective, slightly less likely to describe a justice perspective and more apt to combine the care/justice perspective. Since the numbers of nurses in each category remained small, one nurse made a difference in the overall results. Further study is warranted.

The relationship between neonatal intensive care unit experience and moral voice predominance is shown in Table 17. Again nurses who had fewer years of experience were less likely to function from a care perspective. Numbers remain small but the trend seemed suggestive. Seven nurses who had practiced 1-5 years (58.3%) used the care perspective.

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Table 16

Relationship Between Years Practicing as a Registered Nurse and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Years Practicing | No. | % | No. | % | No. | % | No. | % |
| 1-5 | 7 | 58.3 | 1 | 8.3 | 4 | 33.3 | 12 | 100 |
| 6-10 | 5 | 62.5 | 2 | 25 | 1 | 12.5 | 8 | 100 |
| 11-15 | 2 | 67 | 0 | 0 | 1 | 33 | 3 | 100 |
| 16-20 | 2 | 100 | 0 | 0 | 0 | 0 | 2 | 100 |
| Over 20 | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Nurses who had practiced from 1-5 years demonstrated an increased frequency of the care/justice perspective (4 nurses or 33.3%) compared to the sample as whole. Only one nurse (8.3%) who had practiced five years or less described a justice perspective when making moral decisions. Nurses who had practiced 6-10 years came close to the sample average for discussing moral dilemmas from a care perspective. However, the justice perspective was identified by two nurses (25%) and the

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care/justice by one nurse (12.5%). Six nurses had worked in neonatal intensive care over ten years. All but one described moral dilemmas with a care predominance.

Table 17

Relationship Between Neonatal Intensive Care Unit (NICU) Experience and Moral Voice Predominance

| Years NICU Experience | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| | No. | % | No. | % | No. | % | No. | % |
| 1-5 | 7 | 58.3 | 1 | 8.3 | 4 | 33.3 | 12 | 100 |
| 6-10 | 5 | 62.5 | 2 | 25 | 1 | 12.5 | 8 | 100 |
| 11-15 | 4 | 80 | 0 | 0 | 1 | 20 | 5 | 100 |
| 16-20 | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

Based on the fact that interviewees with one to five years experience as registered nurses in neonatal intensive care seemed less likely to identify care as their moral perspective, the researcher decided to look more closely at this subgroup. The group of nurses who had practiced five years or less were the identical nurses who had five years of neonatal intensive care

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unit experience or less. Table 18 depicts the relationship of registered nurses practicing five years or less to moral predominance. Findings further verified that younger nurses were less likely to practice from a care perspective. Only one nurse, with one to two years experience, identified care as her predominant voice. One nurse identified justice and one also identified a care/justice perspective. Three (50%) of the nurses who had been in practice for two and one-half to three and one-half years discussed moral dilemmas from a care perspective. This was 15% lower than the sample as a whole. Three nurses (50%) also discussed dilemmas from a care/justice view point. This was 27% higher than the sample population. All of the nurses who had practiced for four to five years did so from a predominance of care.

Further credence to the finding that nurses moved toward a care perspective with experience was heard as nurses described changes in their moral decision making since beginning practice. The following quotations gave evidence:

> When you're first learning your skills and everything you concentrate more on doing the skill. You don't really concentrate on how the baby is feeling during what you're doing. Like starting I.V.s, sticking. [sic] Now I'm thinking more about how I can prevent pain in this baby. I'm

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thinking more of comfort measures. I'm really not focusing on the skills anymore (Interview 33, p. 6).

Table 18

Relationship Between Registered Nurses Practicing Five Years or Less and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Years Practicing | No. | % | No. | % | No. | % | No. | % |
| 1-2 | 1 | 33.3 | 1 | 33.3 | 1 | 33.3 | 3 | 100 |
| 2 1/2 - 3 1/2 | 3 | 50 | 0 | 0 | 3 | 50 | 6 | 100 |
| 4-5 | 3 | 100 | 0 | 0 | 0 | 0 | 3 | 100 |
| Totals | 7 | | 1 | | 4 | | 12 | |

This nurse began to practice by concentrating on procedures and protocols. She had to learn skills first and as a result did not think much about what the baby was experiencing. Now she practices more attuned to the baby's comfort needs.

When you first start, . . . I had this great idea that you're a nurse and all you're going to do is save lives and do everything that you can to make people survive, and then I started working in the nursery and realizing that maybe it

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> wasn't best for every single baby to survive. . . . I've suddenly changed my views. . . . Just seeing the different babies and what happens to them and how long they survive or what they go through to survive, and what they turn out like afterwards makes a difference (Interview 57, p. 12).

As illustrated in this quote, the nurse began practicing thinking that she would do all she could do to save lives. Saving lives was the rule that dictated her practice. Then she realized the fruits of her labor in the neonatal intensive care nursery. She saw all the suffering the babies endured in order to survive. Despite the suffering, sometimes the outcome was very far from perfect. She began to wonder if life at all costs was the answer. Based on such experiences, she decided there was more to nursing than just saving lives.

> Well, I guess when you're first starting as a nurse you're thinking about the technical things, thinking about the blood gases and getting out on time and your technical skills and now that I have my technical skills I think that you have more time and more awareness of the total picture. . . . I look at a lot of different sides of the story more than I used to. . . . I have seen so many different types of situations and everyone is different. I think the important thing is that they need to be individualized in the family. They don't need to have these blanket rules that apply across

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the board because every situation is so different (Interview 30, p. 9).

The interviewee described how following procedures correctly was of great concern to her as she first began caring for babies. After becoming technically proficient, the nurse realized the importance of looking at the bigger picture. In particular, she recognized the significance of individualizing care given to both the baby and family. Broad rules, part of a justice framework, did not work.

The findings of this study support that new graduates enter nursing practice with the intention of practicing from a justice perspective. They look for rules to guide their actions and are most concerned about following procedures and protocols correctly. As a result younger nurses in the profession did not identify care as the predominant moral theme when describing an ethical dilemma. Once concerns about technical expertise were no longer an issue, the nurse then strove to prevent pain, considered what the future may hold for the sick neonates, and individualized care. These new goals were readily identifiable as themes of the care perspective. Now the nurse was more likely to identify care as the predominant moral voice.

Nurses discussed what had helped them deal with moral dilemmas in their clinical practice. Consistently they identified experience and their own maturity. Experience

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resulted in skill proficiency. In addition, experience gave them a background from which to draw from for decision making. It became clearer what to expect and what was not realistic. With experience comfort for the baby, individualizing care, and/or concern for the future became more important. Maturity, in terms of encountering numerous situations and relationships in life, gave the nurses further experience to draw from. With professional experience and personal maturity, care often became the identified perspective for decision making.

The relationship between years of experience in this particular neonatal intensive care unit and moral voice predominance was also examined. Findings are found in Table 19. Generally the perspective the nurses described based on this variable varied very little from the sample as a whole. Care did increase with longer experience in the unit, but this seemed to be a carry over from the finding that care increased with more experience as a registered nurse in general.

Hours Employed Per Week

The nurses were also asked how many hours per week they were currently employed in neonatal intensive care. The relationship between hours employed and moral voice predominance is shown in Table 20. Nurses who worked 20-29 hours per week described more moral dilemmas from a care perspective than the sample population as a whole and also than those who worked from 30-39 hours or 40

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or more hours per week. This finding was of particular interest when coupled with data from the interviews.

Table 19

Relationship Between Current Unit Experience and Moral Voice Predominance

| Years Experience in Current Unit | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| | No. | % | No. | % | No. | % | No. | % |
| 1-5 | 10 | 62.5 | 2 | 12.5 | 4 | 25 | 16 | 100 |
| 6-10 | 4 | 66.7 | 1 | 16.7 | 1 | 16.7 | 6 | 100 |
| 11-15 | 2 | 67 | 0 | 0 | 1 | 33 | 3 | 100 |
| 16-20 | 1 | 100 | 0 | 0 | 0 | 0 | 1 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

"For me, leaving full time here has made a big difference. . . . Being here everyday, everyday, day in and day out, got really stressful" (Interview 54, p. 8).

"When I was full time, I mean, you just do get burned out here. You know, the high stress, the kids, the sick babies, kids dying. You just need to get away for awhile" (Interview 53, p. 9).

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Table 20

Relationship Between Hours Employed in Neonatal Intensive Care and Moral Voice Predominance

| Hours Employed per Week | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| | No. | % | No. | % | No. | % | No. | % |
| 20-29 | 4 | 80 | 0 | 0 | 1 | 20 | 5 | 100 |
| 30-39 | 4 | 66.7 | 1 | 16.7 | 1 | 16.7 | 6 | 100 |
| 40 or more | 9 | 60 | 2 | 13 | 4 | 27 | 15 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

The nurses interviewed in this study indicated that stress at times got in the way of caring. Stress in neonatal intensive care has been well documented by Jacobson (1983) and Marshall and Kasman (1980). Both of these earlier studies suggested escape from work as an adaptive strategy that has received little recognition as a legitimate coping mechanism. Certainly many, if not most nurses, intend and need to work full time. Perhaps mental health days or time out from patient care as suggested by Jacobson might help nurses more effectively deal with stress and thereby approach dilemmas from a more caring perspective.

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## Primary Nursing

Table 21 documents the relationship between functioning as a primary nurse and moral voice predominance. Since only five nurses in the sample did not function as a primary nurse, findings were far from conclusive. Three of the five nurses did identify care as their primary perspective, one identified justice, and the final nurse identified a combined care/justice perspective. Since the nurses interviewed in this study were purposely selected because of having direct contact with babies, it is not surprising to the researcher that 21 of the 26 (81%) functioned as primary nurses.

Table 21

Relationship Between Functioning as a Primary Nurse and Moral Voice Predominance

| | Moral Voice Predominance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Care | | Justice | | Care/Justice | | Total | |
| Hours Employed per Week | No. | % | No. | % | No. | % | No. | % |
| Yes | 14 | 67 | 2 | 9.5 | 5 | 23.5 | 21 | 100 |
| No | 3 | 60 | 1 | 20 | 1 | 20 | 5 | 100 |
| Totals | 17 | | 3 | | 6 | | 26 | |

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## Summary

Due to the homogeneity of this small sample, the relationships between moral perspective and demographic variables were not conclusive. Interesting trends were suggested, however. The researcher was able to document through identification of moral perspective, demographic data, and interview material that nurses who are older in age, have more years in the profession, and have more neonatal intensive care experience were more likely to practice from a care perspective. Nurses appear to move from concern with justice's rules and rights to care for self and others.

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# CHAPTER V

# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

## Summary

The results of this study indicated that nurses use more than one perspective as they make moral decisions. The predominant number of nurses used a perspective of care, although some combined a care and justice perspective, and a small number used a justice perspective. This is important in lending credence to Gilligan's (1982, 1987) theoretical framework of moral development as appropriate in explaining moral decision making by nurses who work in neonatal intensive care. All nurses expressed an understanding of both the care and justice perspectives. When discussing moral decisions, the nurses interviewed described concerns from both perspectives.

Of the nurses interviewed in this study, 65% identified care as the predominant perspective when deliberating a moral dilemma. A care taxonomy was identified which included the following components: not hurting, welfare of others, attachment and connection, appreciation of differences, and care of self.

These categories are very similar to those identified by Brown (1989) when she interviewed adolescent girls, ages 7-16. Brown's interdependence category was not singled out as a separate division in this research since it seemed to be subsumed in all categories of care. Only the category of inclusion was



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identified by Brown, but not this researcher. This researcher speculated that nurses in professional circumstances were well aware of the importance of including everyone who should be involved in the decision making process. The issue of inclusion, in this study, was actually more of a justice concern than a care concern. The nurses identified role inequality as a problem that at times resulted in the exclusion of those with lower status as moral decisions were made.

The nurses' descriptions of their moral decision making led the researcher to recognize that they were resolving issues from either Gilligan's goodness as self sacrifice or morality as nonviolence levels. The nursing experience of caring is thus, also a moral perspective.

A smaller percentage of nurses (12%) identified justice as their predominant moral perspective. The justice perspective in this study was also described as a taxonomy with the following components: legal issues, rights, rules, obligations and commitments, societal concerns, and roles.

All categories purposed by this researcher were also addressed by Rogers and Gilligan (1988). However, three of Rogers and Gilligan's categories were not found in interviews with neonatal intensive care nurses. These three classifications include concern for separation, independence, autonomy, or individuality; empathy as role-taking or reciprocity; and concern

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with personal freedom, choice, ambition, and self-fulfillment. The researcher believed that these categories were of less importance when discussing professional moral dilemmas than when describing personal dilemmas. In addition the small number of nurses who identified justice as a predominant perspective may have resulted in less categories being identifiable.

Neonatal intensive care nurses in this study validated the existence of three of Kohlberg's (1976, 1978) moral development stages. These included the third stage of mutual morality, fourth stage of social system morality, and fifth stage of social contract morality. The fact that only three nurses used this perspective predominantly in making moral decisions, however, suggested that another perspective may be more relevant for nursing.

Twenty-three percent of the nurses interviewed combined the care/justice viewpoints as decisions concerning moral dilemmas were deliberated. This finding validated Brown's (1988), Gilligan's (1987), Gilligan and Attanucci's (1988) work which purported that the justice and care perspective could be integrated throughout the interview and neither actually predominate.

A perspective other than care, justice, or the combination of care/justice was not identified. Beneficence and an ethic of good (Penticuff, 1989) were apparent in the interviews with

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neonatal intensive care nurses, but it seemed most appropriate to acknowledge this perspective as a part of care. This is in keeping with previous work by Brown (1989) and Rogers and Gilligan (1988).

The relationship of demographic variables to the perspective used by neonatal intensive care nurses when considering moral dilemmas illuminated some interesting trends that deserve further study. Most important, perhaps, was the fact that nurses who were younger in age, younger in the profession, and who had fewer years of neonatal intensive care experience were less likely to practice from a care perspective. From the demographic questionnaires and the interviews, it was determined that with professional experience and personal maturity, care often replaced care/justice as a perspective of decision making.

Other trends that bear further study include the relationship of the nurses' religion and moral perspective. In this study, a large number of nurses raised in the Catholic religion functioned from the care perspective. Nurses raised in Protestant denominations were more likely to practice from the care/justice perspective. Only six nurses were raised as Protestants, however,

Nurses who worked 20-29 hours per week described more moral dilemmas from a care perspective than the sample population was a whole and also those who worked more than 29 hours per week.

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Again coupling this data with interview data, it appeared nurses who worked part time were more likely to practice from a care perspective. Stress at times seemed to have gotten in the way of caring for some of nurses who worked more hours per week.

The relationship between participation in continuing education or inservice programs on nursing ethics or nursing issues indicated that nurses who attended were less likely to practice from a care perspective. One explanation for this is that most nursing ethics is based on normative ethics or a Kohlbergian approach, which stresses justice as a moral principle. Such an interpretation does not necessarily explain why a similar phenomenon occured when nurses participated in nursing issues programs, however. All nursing issues programs do not concern ethics.

There was little relationship between moral perspective and marital status or presence of dependents and/or children. In addition, the homogeneity of the sample prevented the researcher from ascertaining if a difference in moral perspective was dependent upon race, original nursing preparation, highest degree attained, or whether the interviewee practiced as a primary nurse or not.

## Conclusions

This study documented that it is imperative that nurses move beyond Kohlberg's (1971, 1976, 1978) theory of moral development

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based on justice and incorporate Gilligan's (1982; 1987) more recent theory in moral development that includes a perspective of care, as well as justice. These two perspectives are different ways to organize thinking. The justice framework is concerned about treating others fairly, while the care perspective endeavors to never turn away from someone in need. Nurses interviewed understood and used both perspectives as they made moral decisions, but neonatal intensive care nurses were more likely to deliberate moral dilemmas from a care perspective. Neither can be eliminated.

In addition, nurse researchers must also continue to determine if there is an additional perspective that remains to be identifed. In this study, nurses discussed beneficence within the context of caring. It may be appropriate at some point to further differentiate beneficence from caring. A question in this researcher's mind concerns the difference between beneficence from a caring perspective versus beneficence from a justice perspective.

Ethicists identify at least three major ethical principles: a) justice, b) beneficence and, c) autonomy. Justice has already been identified as a perspective for making moral decisions. There appears to be some evidence that beneficence is also involved in such decision making. Where does autonomy fit? Autonomy refers to a self-governing person or when that person

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acts in a self-governing manner (Silva, 1990). Allowing patients or families to act autonomously can come from either a care or justice perspective. For example, the nurse might encourage a family to act autonomously because of the specifics of the situation or connections between various people. This encouragement would proceed from a perspective of care. Believing autonomy is a right for all people as they interact within the health care system, is a view of autonomy from a justice perspective. Thus it appears autonomy can be a guiding ethical principle from either perspective.

All nurses interviewed by this researcher, without exception, raised both care and justice concerns. This combined phenomenon continues of particular interest as Gilligan reported in 1987. The metaphor of interpreting through a different lens (Brown, 1988), depending on one's perspective, remains a viable pictoral representation of changes that occur in one's perspective. The situation is viewed from more than one angle as one moves from care to justice and vice versa. The fugue metaphor (Gilligan, Brown, & Rogers, 1988) also continues to represent meaningfully the different perspectives of moral development.

Most research tools concerning moral development used in nursing research are based on Kohlberg's (1971, 1976, 1978) theory. Again, these tools were developed under the assumption

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that all people strive to deliberate dilemmas from a justice framework. Since this study verified that not all nurses deliberate moral dilemmas from a justice perspective, it is questionable to continue studying nursing using tools so narrowly developed.

A key variable identified in nursing research studies on moral development has been education. A higher educational level has been correlated with higher levels of moral development in studies by Crisham (1981), Davis (1981), Felton and Parsons (1987), Ketefian (1981a, 1981b), Mayberry (1986), and Munhall (1980). The nurses in this study also suggested that professional experience and personal maturity are important as nurses make moral decisions. A developmental progression was described that moved from concern about procedures and protocols to concern about the baby's total situation.

Previous research has unsuccessfully attempted to correlate moral development with other demographic factors. It is not surprising that previous nursing research based on Kohlberg (1978) has not identified a correlation between moral development and age. This study suggested that care became the more predominant perspective as age and experience increased. This explains why moral development based on a justice framework did not progress with age. Crisham (1981), Ketefian (1981b), and Mayberry (1986) reported that nurses with less experience

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exhibited greater principled reasoning ability. Again in this study, nurses indicated they moved from a justice to a care oriented perspective with experience and maturity. No wonder the more experienced nurses did not score higher on a research tool that measured justice. It appears that previous researchers' attempts to correlate demographic factors with moral development were based on tools with questionable validity for nurses, who more frequently practice from a perspective of care rather than justice.

Wilkinson (1987/88) determined that nurses experienced moral distress most frequently when confronted with cases concerning a) prolonging life, b) performing unnecessary tests and treatments, c) situations involving lying to patients, and d) incompetent or inadequate treatment by a physician. Many of the stories told to this researcher by neonatal intensive care nurses centered on these same concerns. Of the above cases, only situations involving lying to the patient were not discussed with this researcher. Obviously, the patient in this study was a neonate. Nurses were concerned when physicians did not give parents and family members adequate information, however.

This study has determined that nurses use a perspective of care, justice or a combination of care/justice as they make moral decisions. This has significant implications for nursing since it suggests that nursing must go beyond the Kohlbergian framework

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and incorporate a theoretical perspective that affirms the importance of both care and justice. In addition, the recognition of care as a perspective for making moral decisions further affirms the significance of caring as a major theoretical concept of the profession of nursing. A nurse caring is a moral experience, as well as a clinical experience.

## Recommendations

Recommendation concerning research, theory development, and education and practice are apparent based on the findings of this study. The recommendations are presented as a stimulus for additional work in this area.

### Research

Numerous research studies are a natural follow up to this study. In fact, this study suggests more questions than the five that it answered. The researcher recognizes that research in this area of moral development and its connection to care in nursing could easily become her life's work.

The following research questions are identified as needing further study:

1) What perspective do nurses working in other settings use as they make moral decisions?

2) What perspective do male nurses use as they make moral decisions?

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3) What perspective do nurses from different ethnic or racial backgrounds use as they make moral decisions?

4) Do nurses from different religious backgrounds make moral decision differently?

5) Do nurses with different basic nursing preparation make moral decisions differently?

6) How does the experience or anticipation of parenting effect nursing practice in neonatal intensive care?

7) How does the experience or anticipation of parenting affect moral decision making in neonatal intensive care?

8) Does having taken a nursing issues course in one's basic nursing program effect one's perspective for making moral decisions?

9) What effect does participation in continuing education or inservice programs on nursing ethics have on the perspective used in moral decision making?

10) What effect does participation in continuing education or inservice programs on nursing issues have on the perspective used in moral decision making?

11) Is attendance at continuing education or inservice programs related to ethics or nursing issues effect the perspective used to make moral decisions?

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12) Can the developmental sequence identified in these neonatal intensive care nurses be replicated in other nursing populations?

13) What is the relationship between moral decision making perspective and number of hours worked per week?

14) Can the taxonomies of care and justice be replicated in similar and/or different samples?

15) What perspective do other health care personnel use as they make moral decisions?

16) What perspective do patients and/or family members use as they make moral decisions affecting health issues?

17) What is the significance of a combined care/justice perspective? Is it possible, with further deliberation and discussion of numerous moral dilemmas, that one perspective would dominate? Does a combined perspective represent a higher level of moral decision making than the predominant use of one perspective?

18) Can further differences and/or similarities be identified between nurses who function from different perspectives?

19) What perspective do nurses in administrative positions use as they make moral decisions?

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## Theory Development

In addition to the suggestions for future research, it behooves nursing to continue making connections between a perspective of care for moral decision making and caring as a human science and concept integral to the practice of nursing. Connections between the ethical principle of justice and justice as a perspective of moral decision making need to be developed also. Questions remain concerning if and if so, how, beneficence and autonomy fit into the perspectives of moral decision making. Much research and theoretical work remains to be done.

## Education and Practice

Implications from this study also present for nursing education and practice. Educators must continue striving to incorporate care into nursing curricula. Nurses in this study seemed more comfortable as members of the profession when they began making moral decisions from a care perspective. Teachers of nursing should encourage students to view ethical dilemmas from the care perspective, as well as the justice perspective. Previously nursing ethics has followed the Kohlberg (1978) line of thinking and may not have given adequate attention to the care framework. Research is needed then to document if nurses who are educated in more than one perspective of moral decision making, have an easier time adjusting to the role of practicing nurse when moral dilemmas present. This suggestion, of course, is

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based on the assumption that students are given time to explore ethical dilemmas in their educational program, either in a separate course or as is integrated into their nursing courses.

## Ending

The findings of this study encourage nurses to jump on the Gilligan band wagon. Nurses are concerned with care and justice. Both perspectives are important to understanding the true voice of our profession.

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APPENDIX A

DEMOGRAPHIC DATA SHEET

Instructions: Please select the number that corresponds to your response. Please circle one answer to the right of each question unless otherwise instructed. Thank you.

PERSONAL DATA

1. Age in years: _____

2. Racial/Ethnic Background:

| | |
|---|---|
| White | 1 |
| Black | 2 |
| Hispanic/Mexican American | 3 |
| Asian | 4 |
| Other Please specify:_____ | 5 |

3. Marital Status:

| | |
|---|---|
| Single | 1 |
| Married | 2 |
| Separated or Divorced | 3 |
| Widowed | 4 |

4. Dependents:

Does anyone depend on you for financial support and/or personal care?

| | |
|---|---|
| No | 1 |
| Yes | 2 |

If yes, please circle the appropriate response and specify how many.

5. Children 1 Please indicate number: _____

6. Parents 2 Please indicate number: _____

7. Other persons Please indicate number: _____



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8. With what religion are you currently affiliated?

| | | |
|---|---|---|
| None | 1 | |
| Roman Catholic | 2 | |
| Jewish | 3 | |
| Protestant | 4 | Please specify denomination: _____ |
| Other | 5 | Please specify: _____ |

9. In what religion were you raised?

| | | |
|---|---|---|
| None | 1 | |
| Roman Catholic | 2 | |
| Jewish | 3 | |
| Protestant | 4 | Please specify denomination: _____ |
| Other | 5 | Please specify: _____ |

PROFESSIONAL DATA

10. What year were you registered to practice professional nursing?

19_____

11. In what type of program did you receive your basic nursing education?

| | |
|---|---|
| Diploma | 1 |
| Associate Degree | 2 |
| Baccalaureate Degree | 3 |

12. Where did you receive your basic nursing education?

| | | |
|---|---|---|
| USA | 1 | |
| Other Country | 2 | Please specify country: _____ |

13. What is the highest academic credential you now hold?

| | |
|---|---|
| Diploma | 1 |
| Associate Degree | 2 |
| Baccalaureate Degree in Nursing | 3 |
| Baccalaureate Degree in Other Field | 4 |
| Master's in Nursing | 5 |
| Master's in Other Field | 6 |
| Doctorate in Nursing | 7 |
| Doctorate in Other Field | 8 |

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14. How many years have you practiced as a professional nurse? (Please convert part-time practice to full-time equivalents. For example: half-time for 1 year = 1/2 year).

_____

15. Have you had any formal courses in any of the following content areas during any of your educational programs? (Please circle any or all that apply.)

| | |
|---|---|
| Bioethics (nursing and/or medical ethics) | 1 |
| Nursing issues or perspectives | 2 |
| Neonatal nursing | 3 |
| None of these | 4 |

16. Have you attended continuing education or inservice programs within the past 5 years where the major topic was any of the following? (Please circle any or all that apply.)

| | |
|---|---|
| Ethical issues in nursing | 1 |
| Nursing issues or perspectives | 2 |
| Neontal nursing | 3 |
| None of these | 4 |

EMPLOYMENT SETTING DATA

17. Please indicate in full-time equivalents how long you have been employed in your current unit: (Plese convern part-time practice to full-time equivalents. For example: half-time for 1 year = 1/2 year.)

Years: _____

18. Please indicate your total NICU work experience in full time equivalents: (Please convert part-time practice to full-time equivalents. For example: half-time for 1 year = 1/2 year.)

Years: _____

19. What is the total number of neonatal beds in your unit?

_____

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20. What is the funding source or financial auspices of your facility?

Private non-profit 1
Private for-profit 2
Public 3

21. Is your facility affiliated with a religious organization?

No 1
Yes 2

22. If yes, please indicate hospital affiliation:

Roman Catholic 1
Jewish 2
Protestant 3 Please specify denomination: _____
Other 4 Please specify: _____

23. What is the title of your current position? Please circle only one response:

Staff nurse 1
Team leader/charge nurse 2
Assistant head nurse 3
Head nurse 4
Other 5 Please specify: _____

24. What is the average number of hours you work in the NICU per week?

Hours _____

25. Does your unit utilize primary nursing?

No 1
Yes 2

26. If your unit utilizes primary nursing, do you generally function as a primary nurse?

No 1
Yes 2

27. What is the usual staff to patient ratio in your NICU?

_____

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28. Does your hospital have an ethics committee on which nursing is represented?

| | |
|---|---|
| No | 1 |
| Yes | 2 |
| Uncertain | 3 |

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APPENDIX B

Subject Information Sheet

I have been asked to participate as a subject in a research project that will be on moral decision making in nursing.

The purpose of this research is to gain further information about the process of making moral decisions by registered nurses.

This project is under the direction of Pam Chally, R.N., a doctoral student in Georgia State University's School of Nursing. There is no other sponsorship or funding for this project.

If I choose to participate in the project, I understand that I will be asked to fill out a demographic questionnaire and participate in a semi structured interview both of which should take approximately one hour.

I have been told that there are no known risks or discomfort to me from participation in the project, other than mild anxiety and/or frustration evoked from redeliberation of a moral dilemma. There is also not likely to be any direct benefit to me, but knowledge gained from this study may contribute to a better understanding of moral decision making in nursing.

I understand that information gathered from me will not be reported to anyone outside the research project in any manner which personally identifies me. A report of general and combined results from several participants in this project will be prepared for the School of Nursing at Georgia State University, and may be submitted to a professional publication or conference at a later time.

The project investigator, Pam Chally, R.N., has offered to answer any questions that I have about my involvement in this project. Additional questions concerning this research can be addressed to Dr. Kathryn Chance, Dissertation Committee Chairperson, Georgia State University at 404-651-3046. I understand that I may end my participation at any time. Whether I choose to participate at all, or decide not to continue at a later time, will have no effect on my employment or any future relationship with Rush University.

I understand that a signed statement is required of all participants in this project. My signature indicates that I understand and voluntarily agree to the conditions of



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participation described above, and have received a copy of this form.

| | |
|---|---|
| Date | Signature of Subject |

Using language that is understandable and appropriate, I have discussed this project and the items above with the subject and/or authorized representatives.

| | |
|---|---|
| Date | Signature of Project Investigator |

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## APPENDIX C

## DATA ANALYSIS WORK SHEETS*

I. FIRST READING - UNDERSTANDING THE STORY

A. Note Thoughts from the First Reading- e.g., relationships, general moral language, repeated words and themes, contradictions, and key images and metaphors.

Interpretation

*Adapted from Brown, L. M. (Ed.). 1988. A guide to reading narratives of conflict and choice for self and moral development (Monograph No. 1). Cambridge, MA: Harvard University Center for the Study of Gender, Education, and Human Development.



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B. Note all Conflicts
in the section of the
interview discussing moral
conflict and choice.

Interpretation

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II. SECOND READING - SELF

A. Self and the Narrative of Action - What actions does self take in the conflict?

| | |
|---|---|
| 1. Choosing self--Does the narrator see or describe a choice? What is the choice? How is the choice made? | Interpretation |
| 2. What is self describing him/herself as saying and/or doing? | Interpretation |

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| | |
|---|---|
| 3. What is self think or considering or feeling? | Interpretation |

B. Self in Relationship

| | |
|---|---|
| 1. What is the organizing frame(s) for the relationship(s) described in the conflict? | Interpretation |

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C. What is at Stake for Self? Interpretation

Summary Interpretation--Reading for Self

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III. THIRD READING - CARE

A. Is the Care Voice Articulated?

--What evidence do you have? Interpretation

Summary Interpretation--Care Voice

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B. If Care is Not (Clearly) Articulated?

--What would constitute care in this conflict? — Interpretation

C. Does Self Align with Care? How do you know?

--Is the alignment explicit or implicit? What evidence do you have? — Interpretation

Summary Interpretation--Self and Care Voice

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IV. FOURTH READING - JUSTICE

A. Is the Justice Orientation Articulated?

--What evidence do you have? Interpretation

Summary Interpretation--Justice Voice

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B. If Justice is Not (Clearly) Articulated?

| | |
|---|---|
| --What would constitute justice in this conflict? | Interpretation |

C. Does Self Align with Justice? How do you know?

| | |
|---|---|
| --Is the alignment explicit or implicit? What evidence do you have? | Interpretation |

Summary Interpretation--Self and Justice Voice

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V. FIFTH READING - ADDITIONAL PERSPECTIVES

A. Is an additional perspective articulated that does not portray care or justice?

--What evidence do you have? Interpretation

Summary Interpretation - Additional Perspective(s)

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B. Does Self Align with the Additional Perspective(s)
How do you know?

--Is the alignment explicit or implicit? What evidence do you have? — Interpretation

Summary Interpretation--Self and Additional Voices

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# VI. SUMMARY INTERPRETATIONS

## A. The Relationship Between Moral Orientations: Summary Interpretation

## B. Alignment of Self with Moral Orientations: Summary Interpretation

--How would you characterize the relationship between self and moral voice in this interview-narrative?

Interpretation

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# OVERALL SUMMARY INTERPRETATION

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SUMMARY CODING FORM

Case #_____

I. The moral orientations and how they are represented: (check three)

1. Is the justice orientation articulated? yes____ no____

2. Is the care orientation articulated? yes____ no____

3. Is an additional orientation articulated? yes____ no____

II. The relationship between the moral orientations: (check one)

1. Justice predominates _____

2. Care predominates _____

3. An additional perspective predominates _____

4. Both justice and care present, neither predominates _____

5. Both care and additional perspective but neither predominate _____

6. Both justice and additional perspective but neither predominate _____

7. Additional perspective, care, and justice but none predominate _____

III. The Narrative Self:

1. Does the narrative self express an "alignment" in the conflict? (Consider whether or not the narrator comes down on one side of his or her own values. This "alignment" can be determined by the narrative self rejecting the values of another.)

yes ____ no ____

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2. What terms/orientation does the narrator use to frame this "alignment" in the conflict?

justice____care____additional perspective____all perspectives____

care and justice____care and additional perspective____justice and additional perspective____all perspectives____

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