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Educational Preparation and Clinical Experience as Variables in Moral Judgement Development of Staff Nurses

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EDUCATIONAL PREPARATION AND CLINICAL EXPERIENCE
AS VARIABLES IN MORAL JUDGEMENT DEVELOPMENT OF STAFF NURSES

By
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A THESIS

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ABSTRACT

EDUCATIONAL PREPARATION AND CLINICAL EXPERIENCE AS VARIABLES IN MORAL JUDGEMENT DEVELOPMENT OF STAFF NURSES

By

Jacquelyn A. Keehne

The purpose of this study was to compare moral judgement development levels of staff nurses with diverse levels of educational preparation and different lengths of clinical experience. Kohlberg's theory of moral development served as the theoretical basis for this descriptive correlational study. The Judgements About Nursing Decisions (JAND) was used to measure moral judgement in this study. The subjects ($N=115$) were practicing staff nurses in the clinical areas of orthopedics, oncology, medical/surgical care, cardiac care/telemetry, and intensive care services. Varying lengths of clinical experience were reported and the majority recorded a Bachelors Degree in Nursing (BSN) as their highest level of education. Spearman's Rho correlations of the JAND results supported that a relationship did not exist between a subject's level of education or length of clinical experience and the dependent variable knowledge and valuation of ideal moral behavior.

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CHAPTER 1

INTRODUCTION

The Issues

Advances in medicine combined with the evolution of new and complex societal norms require a heightened awareness of moral judgement development in the nursing profession. Few would dispute that nurses are constantly torn between the "miracles of modern medicine" and the values of those they care for. Today's nurse practices in a setting that values life at any cost, sometimes even the cost of prolonging a patient's dying and a family's suffering. However, ethics at the bedside concerns more than decisions related to technology. Nurses frequently must face choices that favor one person over another (Lawrence & Crisham, 1984, p. 57) or involve truth telling and confidentiality. Nurses are frequently asked to participate in procedures with which they disagree or are against their moral principles.

The dilemmas presented above influence the moral judgements made by nurses in practice. These dilemmas are further complicated by diverse levels of educational preparation and clinical experience of staff nurses. The influence of educational preparation on moral judgement

development is supported in research conducted by Rest (1979a). Rest found that levels of education and age differences can account for one's level of moral reasoning, as well as moral actions that one may advocate. In addition, Cassidy and Oddi (1988) found that differences in attitudes toward ethics can be attributed to experience as a registered nurse and a course in ethics. Cassidy and Oddi also concluded " . . .the bureaucratic environment of the health-care system" contributes to one's views on ethics (1988, p. 405).

The employment of a wide range of educationally prepared caregivers makes nursing unique. Any given patient at any hospital in the nation may experience nursing care provided by a diploma prepared registered nurse (Dip. RN), associate degree prepared RN (ADN RN), a bachelors degree prepared RN (BSN), a masters prepared RN (MSN), or even a doctoral prepared RN (PhD) in any one hospital stay.

One may assume that the problem of different levels of knowledge of ethics would resolve by simply educating student and practicing nurses. However, little support, direction, or education is provided to promote the development of moral judgement in the educational or clinical settings. Although nurses are compelled to follow a Code of Ethics (see Appendix A), adopted by the American Nurses Association (A.N.A.) in 1950 with recurrent revisions, this only provides an ethical framework. The ability to respond to moral dilemmas is exclusively left up to the nurse at the bedside.

The lack of knowledge and direction in the educational and clinical settings makes it essential that the study of moral judgement continue. "Exploring the relationships between subjects' moral judgement development and responses to actual moral dilemmas is a beginning step in the process of relating moral judgement assessment to the ethical problems faced in particular life situations" (Crisham, 1981, p. 104). One may study moral judgement development by viewing the process as a conceptual movement.

This conceptual movement involves advancing through a series of hierarchically arranged stages as one advances in moral thinking. The above statement reflects the thinking of Kohlberg, follower of Piaget and creator of Kohlberg's Stages of Moral Development (Crain, 1985) (see Appendix B). Kohlberg's theory suggests that the advancement to higher stages of moral thinking and reasoning will be reflective of more consistent, predictable, and responsible behavior (Kohlberg, Kauffman, Scharf, & Hickey, 1975). Kohlberg's theory supports the belief that it is this responsible behavior nurses must strive for as practitioners.

The present study sought to examine key variables that affect and account for a nurse's level of moral judgement. The data collected may aid in the education of student and practicing nurses. Similar to the thinking of Ketefian (1981b), it is hoped that the findings of this and previous studies will serve to enhance the understanding of levels of

moral reasoning to facilitate a sound moral decision making process. It is this commitment to ethical practice that will " . . . ensure society that members of the profession are exercising high standards of self regulation and are worthy of autonomy and authority to make clinical decisions" (Cassidy & Oddi, 1988, p. 405).

Problem of the Study

The problem addressed in this study was: What effect does one's level of education and length of clinical nursing experience have on a nurses' knowledge and valuation of ideal moral behavior?

Purpose of the Study

The Judgements About Nursing Decisions (JAND) instrument, developed by Ketefian (1984), based on the American Nurses Association Code for Nurses, was used to measure moral judgement in this study (Ketefian granted permission to the author to conduct this research using the JAND instrument, see Appendix C). The purpose of the study was to compare JAND scores of registered nurses who have diverse educational preparation and different lengths of clinical nursing experience. The JAND is described in detail in the Procedures and Methods portion of this thesis.

The examination of nurse's moral judgement as influenced by educational and clinical experience was built upon the work of Crisham (1981). Research conducted by Ketefian (1981a, 1981b) involving critical thinking and educational

preparation as a basis of moral judgement was also used. Both of the above researchers used Kohlberg as the theorist for their work. Kohlberg's framework was used as the theory in this study.

CHAPTER 2

LITERATURE AND CONCEPTUAL FRAMEWORK

Conceptual Framework

The association of cognitive development theory with the domain of moral psychology was first introduced by Piaget in the 1930's (Piaget, 1965). This theory was later expanded by Kohlberg (1969) as a stage theory of moral development. Kohlberg's theory of moral development has served as the theoretical basis for many nursing studies. The theory is applicable in both clinical and nursing education settings (Nokes, 1989, p. 172).

Based on Kohlberg's theory, Rest (1974) developed the Defining Issues Test (DIT). "This test [the DIT] is the one most extensively used by nurse investigators" (Ketefian, 1989, p. 516). Felton and Parsons (1987) used the DIT to study the impact of nursing education on ethical and moral decision making. Ketefian (1981a) also used the DIT to study the relationship between critical thinking, educational preparation, and one's level of moral judgement.

Crisham (1981) later applied the DIT to nursing situations to develop her own instrument to measure moral reasoning, the Nursing Dilemma Test (NDT). Unlike the DIT, the NDT measures

moral reasoning in nursing dilemmas faced in the clinical setting. Crisham (1981) used this instrument to study nurses' responses to general moral dilemmas (hypothetical) versus their responses to moral dilemmas faced in the "real-life" clinical settings.

Like the NDT, the Judgements About Nursing Decisions (JAND) is an instrument based on nursing moral dilemmas frequently faced in the clinical setting (Ketefian, 1984). However, the JAND is unique in that it was designed to measure the actual moral behavior of the nurse in the clinical setting. Since the JAND is based on the work of Kohlberg and it uses the ANA Code for Nurses (1985) many nurse researchers have found this tool appealing. Gaul (1987) used the JAND to study the effect of a course in nursing ethics on both ethical choice and action. Ketefian (1981b) used the JAND to study the relationship between moral reasoning and actual moral behavior. In addition, the differences in perceptions of ethical dilemmas and attitudes toward autonomy were studied by Cassidy and Oddi (1988) using the JAND. The past use of the JAND and Kohlberg's theory of moral development supports the use of this instrument and theoretical framework in this study.

Kohlberg's Theory of Moral Development

The application of Kohlberg's theory to nursing research and education has been strongly advocated in the past decade (Omery, 1983). The foundation of Kohlberg's theory is that

moral judgement develops through stages. Kohlberg and Elfenbein (1975) expand on this concept to state that the stages are "qualitatively distinct" and "form an invariant sequence" (p. 621). The above conclusion is based on years of longitudinal study by Kohlberg and his many followers (Kohlberg, 1973, p. 499). The focus of Kohlberg's study and theory was originally moral development from childhood to early adulthood (age 32) (Kohlberg, 1973, p. 500). However, Kohlberg's work in 1973 emphasized that the stages can be applied to older adults (p. 499). Kohlberg based this application on the fact that many of the crises and turning points in the adult's life are moral in nature (Kohlberg, 1973, p. 499). The following three levels and their accompanying six stages make up Kohlberg's cognitive-developmental theory of moral development.

The first level of moral development identified by Kohlberg is the Preconventional Level. An individual in this level is

. . . responsive to cultural rules and labels of good and bad, right or wrong, but interprets these labels in terms of either the physical or the hedonistic consequences of action . . . or in terms of the physical power of those who enunciate rules and labels (Kohlberg, 1973, p. 499).

Nurses placed in this level may not consciously reason by society's norms when faced with a moral dilemma (Mahon &

Fowler, 1979, p. 4). These individuals can be classified into stage one or stage two.

Stage one individuals are characteristically punishment/obedience oriented. Goodness or badness are determined by the physical consequences one may be subjected to " . . . regardless of the human meaning or value of these consequences" (Kohlberg, 1973, p. 499). Stage two characterizes individuals based on individualism and exchange. This stage of instrumental opportunism encompasses more concrete ideas. The right moral action is one which satisfies the individual's personal needs and only occasionally others' needs. Fairness and reciprocity are key factors, as opposed to loyalty or justice (Kohlberg, 1973, p. 499). Although both stages involve punishment, it is perceived differently in each stage. Stage one reflects punishment as a proof that being disobedient is wrong. In stage two punishment is merely a risk one wishes to avoid (Crain, 1985, p. 121).

Kohlberg identified the second level as the Conventional Level. In this stage immediate consequences are often set aside in hopes of maintaining expectations established by one's family, group, or nation (Kohlberg, 1973, p. 499). These individuals tend to conform to society's expectations in hopes of maintaining the status quo. Nurses in this level may exhibit extreme dedication to their institution to please the administration and maintain conformity to institution rules. This level consists of stages three and four.

Stage three has been characterized as the nice girl/good boy stage and is " . . . typified by those who acquiesce to peer and social pressures to gain the reward of social approval" (Mahon & Fowler, 1979, p. 5). Conformity to stereotyped images is obvious and approval is obtained by being "nice" (Kohlberg, 1973, p. 499). Motivation occurs for the first time in this stage and the individuals may even endure punishment as an attempt to accomplish a stereotyped role. Stage four emphasizes law and order and may be evaluated in regard to conformity. Conformity to persons is also evident in stage three, however, in stage four conformity addresses legal and moral laws and rules. " . . . Stage four subjects make moral decisions from the perspective of society as a whole" (Crain, 1985, p. 122).

The final level identified by Kohlberg is Postconventional Morality. Moral values and principles are evaluated by the individual. These values are not judged based on the authority of groups or the individual's identification with a particular group (Kohlberg, 1973, p. 499). Ketefian (1981a) clarifies this concept by inferring that individuals in this final level autonomously examine their own moral values and personal principles apart from specified norms of their group or culture (p. 99). Once again, this level is broken down into two stages, five and six.

Stage five has been termed the "social contract" stage by

Kohlberg (1973) and numerous other authors (Crain, 1985; Mahon & Fowler, 1979; Omery, 1983). This stage emphasizes individual rights with more advanced legalistic orientation. Stage five individuals view their society from a theoretical standpoint taking into consideration personal duty, the majority's welfare, democracy, human rights, and constitutionality (Mahon & Fowler, 1979, p. 6). Stage five individuals are people " . . . making more of an independent effort to think out what any society ought to value. . . . They are trying to determine logically what society ought to be like" (Crain, 1985, p. 123). Kohlberg points out that although legal in nature, thinking in this stage encourages the changing of laws " . . . in terms of rational considerations of social utility" (1973, p. 499). In fact, the structure of the American government and the writing of the constitution is based on this level of moral thinking (Kohlberg & Elfenbein, 1975, p. 619).

Stage six surpasses stage five by including self selected and logical universal ethical principles. "These principles generally emanate from the person's philosophy of life, which will demonstrate characteristics of breadth, depth, comprehensiveness, and coherence. In this stage, duty exists within the realm of these principles rather than being defined by contractual or legalistic agreement" (Mahon & Fowler, 1979, p. 7). Kohlberg (1973) defines these principles as being "abstract and ethical." They include justice, reciprocity,

equality, rights, and "respect for the dignity of human beings as individual persons" (p. 499).

While examining the relationships of the concepts above, one notes the previously mentioned "invariant sequence" and "hierarchical integrations." Advancement is sequential through each level. Higher stage moral judgement includes all lower stage thinking and judgement (Ketefian, 1981a, p. 99). Advancement to higher stages signifies a conceptual movement that parallels advancement in logical reasoning and cognitive ability. For example, Preconventional and Conventional Level responses rely on external factors. However, when individuals reach the Postconventional Level, they are capable of recognizing " . . . that there exists mutually exclusive, competing rights and values within moral conflicts" (Mahon & Fowler, 1979, p. 6). It is this relationship of moral development to cognitive ability that supports the use of this theory in this study.

In addition, Kohlberg (1973) found that none of the subjects that participated in his longitudinal study attained Stage Five before age 23.

"For some, movement to this stage occurred later and seemed to depend upon: (a) experiences of sustained responsibility for the welfare of others; and (b) under conditions where the basis of this responsibility can be both questioned and affirmed on a universal human basis" (p. 500).

This relationship between moral development and life experience supports the use of this theory in this study.

Review of the Literature

Kohlberg's theory of moral reasoning has been used as a conceptual framework for many nursing studies of moral behavior and judgement. Many of these studies sought to examine the relationship between characteristics of nurses and their level of moral reasoning. Felton and Parsons (1987) conducted a descriptive correlational study to compare the major variables of level of nursing education, attribution of responsibility (the measurement of commission, foreseeability, intentionality, and justification levels of responsibility), and previous ethical/moral dilemma resolution with ethical/moral reasoning level. The researchers used the Defining Issues Test (DIT). The DIT is an objective test composed of six hypothetical moral dilemmas. Developed by Rest (1979b), this highly structured instrument measures the moral choice reasoning process and is based on the work of Kohlberg.

The DIT yields two developmental indices: the P score and the D score. Both are continuous scales and are treated as interval measures. The P index represents the level of principled thinking and is calculated by adding the scores for stages 5 and 6. It is interpreted as the importance given to principled considerations. The D score represents the relative preference for principled

thinking over conventional and preconventional reasoning. It is calculated from all stage scores (2 to 6) and is interpreted as an overall measure of moral judgment (Ketefian, 1989, p. 516).

Felton and Parsons (1987) used a convenience sample of 227 undergraduate nursing students and 111 graduate level nursing students. Graduate nursing students reasoned at a higher level than the undergraduates based on DIT D scores. Graduate students' mean DIT D score was 28.21 versus an undergraduate mean DIT D score of 25.78 ($t=3.00$, $p=.002$). This finding supports the claim that formal education directly affects one's ethical/moral reasoning level. No difference in the groups' scores were found to be based on attribution of responsibility or previous dilemma resolution. This lack of significance for experience with previous dilemmas challenges the role clinical experience plays in the moral reasoning process. The authors did not publish findings showing the testing of DIT P scores.

A descriptive correlational study conducted by Crisham (1981) supports that educational preparation is related to one's level of moral judgement. Crisham also used the DIT instrument and developed a new tool, the Nursing Dilemma Test (NDT). The NDT measures moral judgement, thus reflecting a cognitive process. "The major purpose of the NDT is to measure nurses' responses to recurrent nursing dilemmas and the importance given to moral issues and practical

considerations" (Crisham, 1981, p. 106). Significant correlations between the DIT and NDT were reported, however, the correlation magnitude was not documented. Expert nurses (MSN's) involved in this study scored significantly higher on the DIT and NDT than their counterparts with less formal education. This finding supports the findings of Felton and Parsons (1987), Ketefian (1981a, 1981b), Gaul (1987) and the assumption of Kohlberg's Theory of Moral Development that higher stage moral reasoning is related to one's level of formal education.

The NDT Practical Consideration (PC) scale demonstrated that the instrument can distinguish varying lengths of clinical experience. "The PC index represents the sum of weighted ranks given to practical considerations and is interpreted as the relative importance given to practical considerations in making a nursing moral decision" (Crisham, 1981, p. 108). The NDT PC scores of more-experienced nurses were significantly higher than the less-experienced nurses. However, Crisham (1981) pointed out that although the NDT PC scale did indicate the importance of including practical considerations it did not make well defined distinctions of such a complex variable.

Ketefian (1981a, 1981b) also conducted two descriptive correlational studies with moral judgement as the dependent variable using a sample of 79 nurses. The first of the two studies (Ketefian, 1981a) examined the relationship between

level of nursing education and level of critical thinking with the dependent variable. Ketefian used the DIT instrument and the Watson-Glaser Critical Thinking Appraisal Test. Professional nurses (those with a BSN or above) scored higher on the DIT than technical nurses (diploma or ADN prepared), signifying a higher level of moral reasoning. Significance for this test ($F [1,77] = 9.6444$) was less than .01 level.

As mentioned above, the DIT P score represents only principled level scores (scores only from Kohlberg's stages five and six). Rest (1974) conducted a one-way analysis of variance on DIT P scores from four different levels of educationally prepared subjects to ascertain that the DIT produced variability in average scores. This analysis produced an F value ($F = 48.5$) beyond the significant .01 level. The Pearson product moment correlation between the critical-thinking scores and the P scores on the DIT was .5236 ($p = .001$). This finding supports that critical thinking ability does have a positive relationship with moral reasoning. One-way analysis of variance of DIT P scores of professional nurses were compared to the scores of technical nurses. The groups were significantly different ($F [1,77] = 9.6444$, $p < .01$) supporting the researcher's hypothesis that a difference exists in the moral reasoning process between professional and technical nurses. In addition, 32.9% of the variance of moral judgement was explained by both variables, critical thinking and education.

Ketefian's second study (1981b) used the same sample as the first and included 43 nurses with "professional education" and 36 with diploma or associate degree preparation. This study examined the relationship between moral reasoning and moral behavior. Once again, the DIT test was used to measure moral reasoning. The Judgements About Nursing Decisions (JAND), developed by Ketefian for this study, was used to measure moral behavior.

The Judgements About Nursing Decisions (JAND) used the ANA Code for Nurses as the standard for measuring two theorized dimensions of moral behavior. The first dimension is called 'professionally ideal moral behavior' and is defined as professionally valued and ideal nursing behaviors that are congruent with the principles expressed in the Code for Nurses [Column A]. A second dimension of moral behavior, 'perception of realistically moral behavior,' addresses the extent to which behaviors considered professionally ideal are realistically likely to be implemented in actual practice, given the perceived constraints in existing institutional practice; it is defined as the respondents' assessment of the extent to which nursing actions that are in accord with the Code for Nurses are likely to be carried out in simulated ethical dilemmas [Column B] (Ketefian, 1989, p. 517).

A correlation coefficient of .28 ($p = .01$) resulted from a comparison of DIT P scores and JAND column A scores.

Although this is a weak relationship it is positive, suggesting that one's level of moral reasoning is related to one's knowledge and valuation of ideal moral behavior. A coefficient of .19 ($p = .05$) was found based on a correlation between P scores of the DIT and column B scores of the JAND. Although this correlation, like the latter, is weak it is positive and supports that one's level of moral reasoning is related to one's perception of realistic moral behavior. DIT P scores only predicted 3 percent of the variance of JAND column B scores.

Limitations of the Felton and Parsons (1987), Crisham (1981), and Ketefian (1981a, 1981b) studies must be considered. To begin with, only convenience samples were used. Although this is common for studies of this nature, Ketefian's sample size ($N=79$) was rather small. The studies did not mention or control for the nurses' area of clinical expertise or their practice setting (staff nurse, educator, manager, etc.). The studies also failed to mention or control for the Diploma/ADN ratios. The size and the location of the health care facility employing the subjects was also not mentioned or controlled. In addition, nurses' past experiences with ethical dilemmas were not mentioned.

Need for Further Study

This use of the JAND instrument combined with statistical control over the variables presented above aids in meeting the need for study in this area. This study enhances nursing's

knowledge base in this new and challenging area. Information generated by this study directly affects the ethical component, or need for one, in nursing education and clinical staff development. Results of the implementation of this study would aid in safeguarding society through the promotion of ethically and morally responsible nursing care.

Hypotheses

There is a positive relationship between 1) level of education and 2) knowledge and valuation of ideal moral behavior.

There is a positive relationship between 1) length of clinical nursing experience and 2) knowledge and valuation of ideal moral behavior.

Definitions of Concepts / Terms

Length of Clinical Nursing Experience: The total number of years the registered nurse has worked 16 hours or more per week as a staff nurse.

Level of Education: The highest level of nursing education completed by registered nurses and whether they are taking additional courses. Categories of nursing education have been identified: Diploma prepared, ADN prepared, BSN prepared, and MSN prepared.

Knowledge and Valuation of Ideal Moral Behavior: "Nursing actions in simulated ethical dilemmas that reflect respondents' knowledge of, and upholding of, values as expressed by the Code for Nurses. It is the score on column A of JAND" (Ketefian, 1981b, p. 173).

Moral Dilemma: A situation that results in a conflict in one's moral values requiring a decision to be made by the registered nurse.

Moral Reasoning/Judgement: Synonymous terms " . . . used to refer to the cognitive and developmental process of reasoning about moral choice" (Ketefian, 1989, p. 509).

Ethical Practice: " . . . The domain of nurses' moral behavior, actions, decisions, and ethical decision making regarding ethical dilemmas" (Ketefian, 1989, p. 509).

Moral Choice: The selection of a behavior/response after completion of one's thought process when facing a moral dilemma.

CHAPTER 3
PROCEDURES/METHODS

Introduction

The following descriptive correlational study examined ex post facto the relationship between clinical nursing experience and level of education as they relate to a nurse's knowledge and valuation of ideal moral behavior. This nonexperimental form of research was chosen to simply describe the relationships between the variables stated above. Since the aims of this study were not to detect a cause-and-effect relationship, the descriptive correlational approach was chosen. There was no random assignment to study groups or experimental manipulation of subjects.

Unlike many studies of this nature this research attempted to more thoroughly describe and control for extraneous variables. Variables such as the nurse's area of clinical expertise, the clinical setting, and size and location of the institution that the nurse practiced in were analyzed and controlled. In addition, unlike past studies the Diploma prepared subjects were analyzed apart from the ADN prepared subjects instead of being grouped into one category of technical nurses.

Research Variables

Table 1 identifies the independent and dependent variables of the study. A demographic data questionnaire and the Judgements About Nursing Decisions (JAND) instrument were used to describe these variables.

Table 1

The independent and dependent variables.

Hypothesis	Independent	Dependent
There is a positive relationship between 1) level of education and 2) knowledge and valuation of ideal moral behavior.	Level of education.	Knowledge and valuation of ideal moral behavior.
There is a positive relationship between 1) length of clinical nursing experience and 2) knowledge and valuation of ideal moral behavior.	Length of clinical nursing experience.	Knowledge and valuation of ideal moral behavior.

Sample

Subjects were recruited from three Western Michigan urban, acute-care hospitals after permission was obtained from the research committees at each agency. These facilities were chosen due to their diverse sizes and diverse educational preparation of their nursing staff. In addition, each of the three hospitals offer orthopedic, oncology, medical/surgical, cardiac care/telemetry, and intensive care services. Each of the above institutions treat these specialty areas as separate entities with units and staff unique to the area.

The researcher scheduled appointments with each respective agency's Director of Nursing (and/or comparable person within the institution) and presented the intent of the research project. Any questions were answered at this time. The directors were encouraged to submit a letter of agreement to participate in the study following these meetings. Subjects were recruited from the agencies that chose to participate in the study. Subjects were practicing RNs in the areas of orthopedics, oncology, medical/surgical care, cardiac care/telemetry, and intensive care. Graduate Nurses (GNs), Licensed Practical Nurses (LPNs), Nurse Assistants or Aides (NAs), and Student Nurses (SNs) were exempt from the study.

A convenience sample, as described above, was chosen to generate subjects for this study. This type of sampling procedure was chosen to generate a large number of subjects within the defined area. However, it is important to remember

that this may influence the results of the study. As pointed out by Polit and Hungler (1987), convenience sample subjects may be nontypical of the population in regard to the variables measured in the study (p.210). To be included in the study the subject must have:

1. Been a licensed RN.
2. Worked primarily on one of the specialty units described above.
3. Returned all pages of the JAND and Demographic Data Sheet completed correctly.

After participation in the study was confirmed the researcher arranged meetings with unit managers (Head Nurses or comparable person in the institution) of the units designated above. The purpose, methodology, and expected implications of the study were shared with the unit managers. The unit managers were given a set of written instructions to facilitate the study on their unit (see Appendix D). At this meeting the researcher distributed the study packets to the unit managers. The managers received one study packet for each RN on the unit's staff. The study packets consisted of a consent form to participate in the study, JAND written instructions and an example of a completed JAND section, the JAND instrument, and a demographic data sheet. The instruments will be discussed further in the Instruments and Data Collection sections. Reference may be made to Appendices E, F, G, H, and I, for the materials in the packet.

This study was designed to attempt to alleviate any risks to the subjects. Table 2 represents the potential risks and methods incorporated into the study to reduce or prevent them.

Table 2

Potential risks and methods to reduce the risks

Risks to the subjects	Methods to reduce risks
1. The subject may experience confrontation with their own insecurities in decision making.	1. Subjects were assured in the consent form that these feelings are not abnormal or uncommon and that the researcher can be contacted by phone if any problems arise.
2. Embarrassment of the subject.	2. The demographic data sheet and the instrument were designed so that the subjects would not be able to be identified.
	3. Subjects did not place names on any research materials.

Instruments

Demographic Data Sheet

A demographic data sheet was used to measure the variables of gender, age, length of clinical nursing experience, level of educational preparation, area of clinical practice, and size of the health care facility. (Please refer to Appendix I for the demographic data sheet.) This tool was developed by the researcher.

Judgements About Nursing Decisions (JAND)

The Judgements About Nursing Decisions (JAND) developed by Ketefian (1981b) measures select facets of moral behavior in nursing practice. The JAND consists of six vignettes depicting clinically practicing nurses in simulated ethical dilemmas designed to approximate actual nursing practice. Each vignette is followed by five to seven possible courses of nursing action. Participants in the study were asked to respond to each action in two ways. First, is the action a professionally ideal choice given that there are no constraining factors present in the situation. This first choice of action is represented in Column A of the JAND. The ideal choices developed by Ketefian are represented in Appendix J. Second, does the action represent a realistic choice that the nurse is likely to follow considering possible constraints in the clinical setting. This second choice of action is represented in Column B of the JAND. Only JAND Column A scores were used in this study because the dependent

variable was knowledge and valuation of ideal moral behavior. See Appendix H for the JAND instrument.

Validity and Reliability for the JAND. Two aspects of content validity have been established for the vignettes and possible nursing actions present in the JAND. First, practicing nurse clinicians determined that the ethical domain of nursing practice was represented in the instrument. All aspects of the instrument were assessed and evaluated by experts in nursing ethics for the extent that the nursing actions embodied the tenets of the American Nurses Association (ANA) Code for Nurses (Ketefian, 1984, p. 6).

Responses to the JAND were correlated with responses to the Defining Issues Test (DIT) to establish construct validity. The Pearson's product moment correlation of the two instruments were .28 ($p < .01$) for column A and .19 ($p < .05$) for column B. Although the magnitude of the correlations were not impressive Ketefian (1984) concluded that they provided the JAND with tentative evidence of criterion-related validity (p. 8).

A t-test was completed to compare the respective means of professional and technical nurses in column A of the JAND. Ketefian did not provide the means for each group in this (1981b) publication. This test yielded a t value of -3.39 ($p < .01$) with 77 degrees of freedom. The same groups were compared in column B yielding a t value of -1.73 ($p < .05$) with 77 degrees of freedom. Ketefian (1984) suggests that based on

a thorough literature review distinguishing the theoretical distinctions between the two groups the above findings provide empirical support for the validity of the JAND (p. 9). The coefficient alpha, measuring internal consistency reliability for column A, was .58 in the sample of 79 practicing nurses. Internal consistency for column B was .72 in this sample (Ketefian, 1984, p. 9).

Following the initial studies of the JAND, data were compiled and used as a basis for revising the instrument. The revisions are included in the JAND in its current form. Following these revisions the JAND was administered to practicing nurses (n=311) from four different geographic settings. Cronbach's coefficient alpha method was used to measure the internal consistencies of column A and B as separate scales. The different samples yielded a range of .38 to .42 for the internal consistency for column A. Internal consistencies for column B yielded coefficient alphas ranging from .60 to .73. Ketefian (1984) reports that in all samples tested through 1984, subjects' column A scores are higher than column B scores ($t=32.76$, $df=309$, $p<.001$) (p. 11). Therefore, indicating one's values tend to be higher than their behavior given practical restraints.

Reliability may have been affected by the directions given to the subjects. Subjects were instructed to respond to the nursing actions by what the nurse in the dilemma should do and realistically would do. Therefore, respondents may have

interpreted this as predicting someone else's action not what their action would be in the ethical dilemma. The following study was later conducted to examine this finding.

Based on the previous sample of 311 nurses, 46 nurses were retested two weeks later with a revised set of instructions. The revised JAND required the respondents to answer only once as to whether or not they would be likely to take the nursing action. A two-tailed t-test was completed to compare the initial testing scores of column A with the revised instrument. No significant difference was determined ($t=1.99$, $df=45$, $p>.05$). Column B scores from the original testing were compared using the same technique. This testing revealed a significant difference beyond the .001 level ($t=7.95$, $df=45$) (Ketefian, 1984, p. 12).

The bias explained above is one major limitation of the JAND and any instrument that uses hypothetical situations in gathering data of this nature. One should remember that a nurse's moral and ethical decisions are individually influenced by a wide range of variables. Ketefian (1984) identified the following characteristics as being likely to influence moral choice and responses to the JAND: " . . . organizational context and policies, the presence of actual or perceived sanctions for nonconformist behavior, the degree of perceived and actual latitude in professional autonomy in the work situation, and the relationship of nurses with other health care providers" (p. 16).

Continued use of the JAND in well designed and statistically controlled studies will add information about validity to this instrument. These are just the beginning stages in the study of this dynamic topic. Future studies and the implementation of ethics courses in schools and the clinical setting depend upon the continued testing and refining of such tools. The JAND was once again used in this study. The following section will describe in detail the use of the JAND in data collection and analysis in this study.

Data Collection

As described previously, subjects were recruited from three Western Michigan hospitals. Before the start of data collection unit managers of the previously identified units (orthopedic, oncology, medical/surgical, cardiac care/telemetry, and intensive care) received study packets for each R.N. member of their staff. The packets contained: a consent form to participate in the study (Appendix E), JAND written instructions (Appendix F), an example of a completed JAND section (Appendix G), the JAND instrument (Appendix H), and a demographic data sheet (Appendix I).

The unit managers distributed the materials. Unit managers were encouraged by the researcher to allow staff members approximately 30 minutes to complete the study. Unit managers independently made the decision whether this time would be spent on the RN's break time or during the nurse's working hours.

Each unit was given 20 days from the starting date of the study to complete the instruments. The allotment of 20 days was chosen to allow adequate time for all staff members to complete the instruments. Sealed collection boxes were available for subjects to return their completed JAND and demographic data sheets. The unit managers placed the study collection boxes in an area of their choice. The researcher collected the returned instruments on the assigned day from each participating unit. Instruments not completed by this time were considered ineligible for inclusion in the study. Data analysis began when all completed instruments from all participating institutions were collected by the researcher. The methods of data analysis will be described in detail in the following chapter.

CHAPTER FOUR
RESULTS/DATA ANALYSIS

Characteristics of the Subjects

A total of 465 study packets were distributed among three urban Western Michigan acute-care hospitals. Based on this total, 115 (25 %) returned instruments were considered acceptable for use in the study. The sample consisted of 108 females and seven males. All age groups were represented, with the majority ranging in age from 26 to 35. A distribution of the ages is presented in Table 3.

Table 3

Distribution of the sample by age

Age	Frequency	Percent
18-25	15	13
26-35	45	39.1
36-45	37	32.2
45-56	16	13.9
56 and over	2	1.7

The number of years the subjects had practiced as a staff nurse ranged over many years. Most of the nurses in the study had been practicing at a staff nurse level for 11-20 years. Table 4 depicts the distribution of years of employment as a staff nurse for the sample.

Table 4

Distribution of the sample based on length of practice

Years	Frequency	Percent
less than 1 year	5	4.3
1-5 years	33	28.7
6-10 years	24	20.9
11-20 years	39	33.9
21-30 years	11	9.6
over 31 years	2	1.7

Note. One subject failed to respond to this question.

The nurses in the sample represented three different levels of educational preparation. The majority of the sample recorded a Bachelors Degree in Nursing (BSN) as their highest level of nursing education completed. See Table 5 for the distribution of the educational preparation of the subjects.

Table 5

Distribution of the sample based on level of education

Level of education	Frequency	Percent
Diploma	39	33.9
A.D.N.	35	30.4
B.S.N.	41	35.7

The subjects were asked if they were currently attending courses toward a higher degree. Out of the 115 subjects 22 (19.1%) were currently attending courses. Refer to Table 6 for a breakdown of the degrees these individuals were seeking.

Table 6

Degrees being sought by the subjects returning to school (n=22)

Degree	Frequency	Percent
B.S.N.	10	45.5
B.A./B.S.	4	18.2
M.A.	8	36.4
M.S.N.	1	4.5

Nurses were asked if they felt their nursing education prepared them to address ethical problems in the practice setting. The majority of subjects reported that they were only moderately prepared. Only 5.2% of the subjects reported that they were well prepared. Table 7 displays the distribution of these responses.

Table 7

Distribution of the subjects' perceived preparation

Preparation	Frequency	Percent
not at all prepared	3	2.6
prepared very little	28	24.3
moderately prepared	47	40.9
prepared	29	25.2
well prepared	6	5.2

Note. Two subjects failed to respond.

Although the majority of the nurses involved in the study reported that they were only moderately prepared to deal with an ethical dilemma in the clinical setting, 57 (49.6%) of the subjects reported that they had faced an ethical dilemma in the clinical setting within the past 3 months. These subjects were later asked to describe the type of dilemma they confronted. Based on a total of 57 responses, 12 (10.4%)

reported that the ethical dilemma they were confronted with was participation in providing continuing life-prolonging measures to "Do Not Resuscitate" or "No Code" patients. Five (4.3%) reported participation in removal of life support equipment as the dilemma they were confronted with. In addition, four (3.5%) of the subjects reported a medication error as the dilemma they were confronted with.

All subjects were then asked if they had any life experiences (positive or negative) that may have influenced their ethical decision making ability. Based on the total of 115 responses, 16 (13.9%) reported that their religious affiliation influenced their ethical decision making ability. Ten (8.7%) simply answered "yes" to the question. Nine (7.8%) of the subjects reported that a death in their family had contributed to their ethical decision making. In addition, 5 subjects (4.7%) stated that just their experience as a nurse has had an impact on their ethical decision making ability.

Results

The Judgements About Nursing Decisions (JAND) was the instrument used in the study. Column A of the JAND represents the professionally ideal choice given that there are no constraining factors present in the situation. One's score on this column signifies one's knowledge and valuation of what an ideal moral behavior "should" be. Only JAND Column A scores were used in this study because the dependent variable was knowledge and valuation of ideal moral behavior.

Subject's scores on the JAND column A ranged from 25 to 38, 39 being a perfect score. The majority of subjects recorded 34 or more correct responses. The mean score for this study was 33.821 with a standard deviation of 2.453 (n=106 valid cases, 9 missing cases). See Table 8 for the distribution of subjects' scores.

Table 8

Distribution of JAND A scores

Value	Frequency	Percent
missing	9	7.8
25	1	.9
27	2	1.7
29	2	1.7
30	4	3.5
31	8	7.0
32	11	9.6
33	14	12.2
34	18	15.7
35	17	14.8
36	16	13.9
37	11	9.6
38	2	1.7

Hypothesis one

The first hypothesis states there is a positive relationship between 1) level of education and 2) knowledge and valuation of ideal moral behavior. A Spearman's Rho correlation was calculated ($Rho=.15624$, $p=.10973$) to determine that there is no relationship between the variable level of education and the variable knowledge and valuation of ideal moral behavior (column A score on the JAND). This research hypothesis was rejected.

Hypothesis two

The second hypothesis tested was: There is a positive relationship between 1) length of clinical nursing experience and 2) knowledge and valuation of ideal moral behavior. Once again a Spearman's Rho correlation was calculated ($Rho=-.08755$, $p=.37450$). Analysis revealed that no relationship existed. This research hypothesis was rejected.

Additional findings

The following Kohlberg concepts were used to examine the data for any additional relationships: Many crises and turning points that are moral in nature occur later in an adult's life (Kohlberg, 1973). Also, moral judgement evolves in an invariant sequence, the more ethical dilemmas one is faced with the greater one's moral judgement will be (Kohlberg, Kauffman, Scharf, and Hickey, 1975). Based on the premise that as one matures in chronological age one will have experienced more ethical dilemmas, it was expected that one's

moral judgement would be greater. A Spearman's Rho was conducted using the age of the subjects and their scores on column A of the JAND. A very weak negative correlation was discovered ($Rho = -.22378$, $p = .02111$). Therefore, data collected from the subjects in this study did not support the thinking of Kohlberg presented above.

An additional proposal of Kohlberg's was statistically examined. Kohlberg (1971) stated that educational climates can stimulate one's level of moral development (p. 183). A t-test using whether a subject was currently attending classes and their JAND A scores as dependent variables was completed. These variables were chosen based on the premise that if one was currently attending courses he/she would have a higher JAND score. In this sample, nurses presently attending classes had a mean JAND A score of 32.57 (S.D.=2.68) and nurses not attending classes had a mean JAND A score of 34.13 (S.D.=2.34) ($t = 2.66$, $df = 101$, $p = .009$). This does not support Kohlberg's theory. Subjects in this study who were currently attending courses did not score higher on the JAND.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

Discussion of Findings

Contrary to Kohlberg's theory and the 1981b work of Ketefian, analysis of the data in this descriptive correlational study failed to support hypothesis one: There is a positive relationship between 1) level of education and 2) knowledge and valuation of ideal moral behavior. A Spearman's Rho correlation was calculated ($Rho=.15624$, $p=.10973$) to determine that a relationship did not exist between the variables. These data are distressing to those who advocate advancement in education for the staff nurse as a means of promoting sound morally based practice. However, many factors must be examined before a judgement may be made.

Although Kohlberg's theory has been used extensively in nursing research its main concepts are based on the longitudinal study of young males. It is common knowledge that this population in no way exemplifies the standard nursing population as supported in this research. This study sample contained only seven males (6.1%). Therefore, it may not be appropriate to expect to relate this sample with Kohlberg's theory. New work in the area of moral and ethical

decision making is addressing this issue. The work of Gilligan (1982) examines the unique "moral commitments" that women possess and how past psychological theory may have misrepresented women. Such misrepresentation may result in misconceptions. This may have occurred in this study.

One must also consider the validity and reliability of the JAND as it relates to this study. Remember that the correlations conducted between the JAND and the well tested and respected DIT were low. The Pearson's product moment correlation for column A with the DIT was .28 ($p < .01$). Ketefian herself stated in 1989 that due to the low reliability for column A of the JAND it is not recommended for direct hypothesis testing (p. 518). Possibly the use of other instruments with this or a similar sample would reveal different findings. For example, Crisham (1981), creator of the NDT (a tool designed to measure moral judgement based on a cognitive process) found that a one-way analysis of variance on NDT NP (nurse principled thinking) scores showed a significant relationship between level of education and one's level of moral judgement $F = 3.37$ ($p < .01$). It is hoped that through further study, such as this one, and advances in psychology, such as the work of Gilligan, that more reliable instruments will be developed to test this abstract area of nursing practice.

In addition, Kohlberg's proposal that the exposure to an educational climate or to education itself can stimulate advancement in moral judgement was not supported in this study. To further test this premise a t-test was completed to determine if current attendance in the educational setting influenced JAND scores. Subjects' responses in this study were opposite of those predicted, significant ($t=2.66$, $df=101$, $p=.009$). Due to the inability to establish a relationship between educational exposure or achievement with hypothesis one, clinical experience was examined as the independent variable in hypothesis two.

Kohlberg's theory suggests that advancement in moral reasoning occurs through hierarchial stages. Could this advancement take place by means of clinical experience? Kohlberg (1973) proposed that movement into advanced stages were dependent upon: "(a) experiences of sustained responsibility for the welfare of others; and (b) under conditions where the basis of this responsibility can be both questioned and affirmed on a universal human basis" (p. 500). Both of these situations are relevant to the clinical experience of nurses. There is no doubt that bedside nursing involves a daily responsibility for the welfare of others. However, besides hospital administrated quality "assurance" programs, are nurses examining the outcomes of their work? Are nurses critiqueing the moral dilemmas they face to learn from these situations? If the answer to this question is yes

one may expect the more experienced practitioner to have a higher level of moral judgement development. Therefore, hypothesis two: There is a positive relationship between 1) length of clinical nursing experience and 2) knowledge and valuation of ideal moral behavior was tested.

Statistical analysis revealed no relationship for the hypothesis. In support of other research, this finding could be attributed to the bureaucratic structure of the acute care environment. Ketefian found in her 1985 study that when nurses enter

. . . the work world of an organization, they find work to be segmented and routine; they are expected to adhere to bureaucratic rules and regulations, and to observe a hierarchy of authority. These role demands are perceived to be antithetical to the ideal role that they learned (p. 249).

In addition, one may associate age to the findings presented above. Caution must be taken in concluding that the older the chronological age of the nurse the longer the length of clinical experience he/she must have. Statistics support that the age of the nursing student is rising. More nursing students than ever before are considered "non-traditional" students. Many of these students are parents or grandparents and, according to Kohlberg and Elfenbein (1975), should be advancing through the stages of moral reasoning in a hierarchial manner.

However, in this study when the variable age was correlated to the JAND column A score using a Spearman's Rho a reverse relationship was found. The younger the subject the higher the score on the JAND for column A, or the higher their knowledge and valuation of ideal moral behavior. Contrary to the earlier work of Kohlberg this finding supports a later longitudinal study conducted by Kohlberg which found: "There has been a tendency, however, for a larger proportion of adults to reach Stage five in this generation than in the last one" (1975, p. 619).

This finding could be due to a difference in teaching strategies concerning the area of ethics. In her work on moral development as a component of nursing curricula, Vito (1983) discussed some of the progress nursing has made as a discipline in teaching ethics. Vito discussed the use of "values clarification" versus the traditional "indoctrinative approach to moral education" (p. 108). However, as concluded by Vito, we still have a long way to go in the nursing education process to facilitate and foster moral development (p. 112).

Younger subjects may have scored higher on the JAND due to an increased awareness of the ethical and legal issues that face the staff nurses of today. However, it could simply be a new generation of practitioners. The new generation of staff nurses may have encountered different or more advanced ethical and moral issues in their development than the more

experienced practitioners. Examples include teenage pregnancy, lack of health insurance and ability to pay for health services, AIDS, the prevalence of violent crimes, the use and effect of narcotics. All of these issues are confronting America's young people as they grow and mature. Consequently, our young practitioners are entering nursing with previous exposure to tough moral issues. In support of Kohlberg, exposure to these dilemmas do appear to result in a higher level of moral thought.

Application to Practice/Education/Administration

In this study it was found that ethical dilemmas are frequently encountered in today's acute care settings. Recall that 49.6% of all subjects that participated in this study stated that they had been faced with an ethical dilemma within the past three months in their work setting.

It was also found that unique personal characteristics of the practicing nurse were identified as factors in one's ethical decision making ability. Factors such as a death in one's family or church affiliation were major contributing factors. Practicing nurses must be aware of these factors that may either positively or negatively affect one's moral and ethical decision making ability. Practicing nurses must be aware of the personal biases that they bring to each moral dilemma, to view the matter as objectively as possible and make a decision based on the ANA Code for Nurses.

Nurses themselves must take responsibility for learning in the many ethical situations that surround them. As supported by Mahon and Fowler (1979), in an environment of "questioning and free expression" growth in moral judgement can occur. Nurses must create this environment at the bedside by sharing personal experiences with peers, questioning one another, and seeking expert theoretical guidance. It is only when nursing itself takes on this responsibility for expanding practitioner's knowledge of moral thought that it can take on the responsibility of assisting others to make tough moral choices.

Not only do changes need to be made at the bedside, but before the nurse is ever faced with a "real life" moral dilemma they must be encountered in the nursing education setting. Only 5.2% of the subjects in this study reported that they were well prepared to address ethical problems in their nursing education program. The majority of responses, 40.9%, reported that they were only moderately prepared.

Nursing education must take advantage of structured and "enriched" environments to provide a setting conducive to moral development. According to Rest (1979a), an "enriched" environment is conducive to a thorough and systematic view of the moral situation. This process will then lead to a more complex and advanced level of thinking. These environments can only be found in a classroom setting. Role playing, case studies, and post-clinical discussions can all facilitate

examination of moral dilemmas in a structured manner. Principles of the ANA Code for Nurses may then be examined in the context of the dilemma to facilitate adaptation of the Code for Nurses into nursing practice.

Nursing administration must also recognize the magnitude of this problem. Many practicing nurses are independently making tough moral choices without guidance or support from nursing administration. As stated above, 49.6% of practicing nurses report that they have dealt with an ethical dilemma in the workplace within the past three months. However, educational sessions on ethical decision making continue to be rare in most acute care hospitals.

Specific questions in the JAND vignettes were examined to determine implementation problems of the ANA's Code for Nurses in the clinical setting. A correct JAND vignette response required the nurse to contact the nursing supervisor to let her talk to a patient's wife. In this study 78.3% of the subjects incorrectly reported that they would not contact the nursing supervisor. Nursing administration must then ask themselves why would the staff nurse not feel comfortable in requesting the assistance of the nursing supervisor in this situation? Is this a matter of trust, competence, or lack of knowledge of resources available to the staff nurse?

In a similar situation, a JAND question was supposed to have the correct response of the nurse suggesting to the patient's wife to discuss the situation with the hospital

chaplain and offering to call the chaplain. However, 40% of the subjects reported that the nurse should not do this. Again, is this a matter of trust, lack of knowledge of resources, or is it a religious conflict. Another possibility in both circumstances is that the staff nurse is not willing to advocate for the patient or his family members. Are the nurses that are responding no to these questions not making referrals? If so are their patients receiving complete and thorough health care by means of collaboration, as identified in the ANA Code for Nurses? However, is the referral actually the best response to the situation? This question was examined as both a variable in application to nursing administration and as a limitation of this study.

Limitations of the Study

The referrals mentioned above were regarded as a morally responsible behavior by Ketefian, and, were coded as the correct response to several questions on the JAND. Justification for this response stems from the ANA Code for Nurses. The code calls for the nurse to collaborate with members of the health professions and others to meet the needs of the client. However, the Code also states that the nurse must assume "responsibility and accountability for individual nursing judgement and actions" (American Nurses Association, 1985, p.1). The Code also refers to the nurse as one who "safeguards the client's right to privacy by judiciously protecting information of a confidential nature" (American

Nurses Association, 1985, p.1). The staff nurse placed in either of the situations presented above may feel torn between the principles presented above. As a staff nurse is the morally correct choice to "collaborate" or assume "accountability" and "safeguard the client's right to privacy?"

The questionable validity and reliability of the JAND was also a limitation of this study. Correlations conducted between the JAND and the well tested DIT were not impressive. Pearson's product moment correlation of column A for the JAND with the DIT were only .28 ($p < .01$) (Ketefian, 1984, p. 8). Ketefian later published that a test-retest approach and review of the literature yielded support for the validity of the JAND (1984, p.12). However, reliability of the JAND remains questionable. Ketefian herself published in 1989 that due to the low reliability of JAND column A it should not be used for hypothesis testing (p. 518).

An additional major limitation of this study was that only a convenience sample was utilized. Only the Western Michigan area was studied and only 7 (6.1%) of the subjects were male. The study of such an abstract topic as moral decision making also lends itself to the participants' unique biases and perceptions that cannot be controlled. In addition, biases unique to each acute care facility such as independent policies and the bureaucratic environment could not be controlled. Finally, as discussed by Ketefian (1984)

when subjects are asked to "self-report" behaviors in dilemmas that are moral in nature they may not always represent the actual behaviors they would perform in the clinical setting.

Suggestions for Further Research/Modifications

Continued research in this ever-changing and challenging area of nursing care must continue. As nurses are required to be independent primary health care providers functioning as patient advocates with an increased sense of autonomy, the moral dilemmas they face must be studied. They must be studied not only to determine the areas of need for education in ethical decision making but also to determine the decisions that are actually being made. What are the credentials of the nurses making the decisions? What are the biases that these individuals possess? What role does the facility's bureaucratic environment play in this decision making? What role does a nurse's upbringing and culture play in his/her ethical decision making? All of these are important questions that nursing researchers must address. Continued use and refinement of already developed instruments such as the JAND and the development of new instruments will assist nursing researchers to further examine this new era of nursing responsibility.

Future studies with enough men involved to compare groups would be beneficial for determining if moral decision making differences exist. However, based on the present demographics of the nursing profession the theories and instruments

available must be thoroughly examined to determine their appropriateness for the currently female dominated profession of nursing. Possibly nursing will need to incorporate a new and different theoretical approach to studying the complex variable of moral decision making. Future research in this area will only serve to enhance the development of a sound theory based approach for the education, promotion, and practice of morally responsible nursing actions.

APPENDICES

APPENDIX A

ANA Code for Nurses

Appendix A

ANA Code For Nurses

1. The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.
5. The nurse maintains competence in nursing.
6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.
8. The nurse participates in the profession's efforts to implement and improve standards of nursing.
9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.
10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

American Nurses' Association, (1985). Code for nurses with interpretive statements. Kansas City, MO: Author.

APPENDIX B

Kohlberg's Theory of Moral Development

Appendix B

Kohlberg's Theory of Moral Development

Preconventional Level of Moral Development: Externally established rules determine right or wrong action.

Stage 1: The Punishment-Obedience Orientation. The child focuses on avoiding punishment or negative physical consequences; deference to authority is strong.

Stage 2: The Instrumental-Relativist Orientation. Whatever provides personal satisfaction is viewed as the right action. Elements of fairness are present, but these are interpreted in a pragmatic way.

Conventional Level of Moral Development: Expectations of family and group are maintained; loyalty and conformity to the existing social order are considered important.

Stage 3: The Interpersonal Concordance or "Good Boy-Nice Girl" Orientation. Whatever is pleasing and brings approval from others is considered good behavior.

Stage 4: "The Law and Order" Orientation. One has to do one's duty and actively maintain the social order because of respect for its underlying morality.

Postconventional Level of Moral Development: The individual autonomously examines and defines moral values and principles as apart from the group norms or the culture.

Stage 5: The Social-Contract, Legalistic Orientation. Individual rights and standards agreed to by the whole society are critically examined, and those define the right action. The person is aware of the relativist nature of values and opinions, emphasizes the "legal point of view" but with the ideas that the law can be changed if rational considerations so indicate. The American government and Constitution are said to belong to this stage of morality.

Stage 6: The Universal-Ethical Principle Orientation: Decisions of conscience dictate what is right. The person chooses ethical principles that appeal to logical comprehensiveness, universality, and consistency; they

are abstract rather than concrete. The universal principles observed are those of justice, reciprocity of human rights, and respect for individual person's dignity.

Ketefian, S. (1981a). Critical thinking, educational preparation, and development of moral judgement among selected groups of practicing nurses. Nursing Research, 30, p. 99.

APPENDIX C

Ketefian Letter of Permission



THE UNIVERSITY OF MICHIGAN
SCHOOL OF

NURSING

October 30, 1990

Jacquelyn A. Keehne, R.N., B.S.N.
4485 Ottawa Trail
Shelby, MI 49455

Dear Ms. Keehne:


You have my permission to make use of the Judgments About Nursing Decisions for your master's research project. You may reproduce it in the appendix of your project, if this is required. I note your acceptance of the other conditions reiterated in your October 23rd letter.

You can find additional information on the JAND, along with some comparative data with other tools in the Annual Review of Nursing Research, Vol. 7, which has an essay by me.

Please send me a check for \$7.00 made out to The University of Michigan, to cover the cost of duplication and postage. Thank you.

My best wishes.

Sincerely yours,


Shaké Ketefian, Ed.D., R.N., F.A.A.N.
Professor and Associate Dean for
Graduate Studies

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Enclosures

APPENDIX D

Instructions for Unit Managers

Appendix D

Instructions for Unit Managers

I am asking your assistance in the data collection for a study entitled "Educational Preparation and Clinical Experience as Variables in Moral Judgement Development of Staff Nurses." As the name implies, the study will be examining nurses with varying levels of education and years of clinical experience as they impact on the moral judgement and ethical decision making process. It is believed that the findings of this study will encourage the development of extensive ethics courses in the clinical and nursing education settings.

Study packets will be made available for all members of your staff. I am asking your assistance in the distribution of these packets. Completion of the study materials should not take longer than 30 minutes. Staff members will be instructed to return their completed studies to a sealed collection box in a place designated by you. All participants will remain anonymous and the institution will not be identified in the final report and presentations. Only group data will ever be presented. I will return 10 days after the start of the data collection to collect the completed studies, all studies not completed by that time will be considered ineligible. A copy of the study results will be made available to you.

If you have any questions or concerns please feel free to call anytime at 616-861-4864. Thank you so much for your cooperation and time. A study of this magnitude would not be possible without your assistance.

APPENDIX E

Consent form for Subject Participation

Appendix E

Consent form for Subject Participation

INFORMATION AND INFORMED CONSENT FOR RESEARCH PROJECT PARTICIPANTS

The study in which you are being asked to participate is titled, "Educational Preparation and Clinical Experience as Variables in Moral Judgement Development of Staff Nurses." As a participant in this study you are being asked to give permission to the researcher to gather information directly from you. This information includes a brief data sheet. Completion of the information requested above will take about 30 minutes and will require you to follow a few simple directions.

Every effort will be made to protect your confidentiality. All data collected will be coded with a number - your name will never be attached. All reports, papers, and articles will report findings in a group format - no individual data will ever be reported. It is not anticipated that you will be harmed in any way by participating in this study. For some, the questions asked in the Judgements About Nursing Decisions questionnaire may bring about feelings of insecurity in ethical decision making. Should this occur, the researcher will be available to answer any questions and/or refer you to appropriate resources. Neither the researcher (Jacquelyn A. Keehne), Grand Valley State University, or Hackley Hospital will accept any financial responsibility for these referrals. Return of the completed JAND and demographic data instruments will be considered consent for participation in the study. Please keep this consent form for your records.

The personal (and direct) benefits to you are limited. The results of this study will help assess practicing nurses moral judgement and ethical decision making abilities.

This study is being conducted by Jacquelyn A. Keehne. She is a registered nurse at Hackley Hospital and a masters in nursing candidate at Grand Valley State University. If you have any questions she can be contacted at the following number 616-861-4864.

I have read and understand the information presented above. I consent, of my free will, to participate in the study.

Participant

Date

APPENDIX F

Judgements About Nursing Decisions Instructions

Appendix F

Judgements About Nursing Decisions Instructions

JUDGEMENTS ABOUT NURSING DECISIONS

You will find six stories here where a nurse finds herself in a dilemma as to what to do. Various courses of action that a nurse might take are listed following each story; you will be asked to respond to each course of action.

There are times when a nurse may believe and think that s/he should, from a professional point of view, act in a certain manner, but because of various roles and other limiting factors that exist in an organization s/he may not always be able to act according to her/his belief. Recognizing this added dimension of conflict you are asked to respond to each action in two ways. First, follow if there were no constraining factors present (Column A). Second, respond in terms of its being a realistic choice that a nurse is most likely to follow, considering possible constraints that may be present (Column B).

Different nurses will have different views on these matters, and it is your view that is sought for each of these stories, and for each of the nursing actions in Column A and Column B. You need not feel that your answers have to be different for Column A than they are for Column B. They may be similar, or they may be different; it is your honest judgment in each instance that we seek.

Please note that the nursing actions listed are not mutually exclusive, in that taking one particular action does not mean that the nurse may not take any of the other actions listed.

A suggestion only: It may be simpler if you went through all the actions and answer Column A first, then went back to the list of actions and answer Column B.

At no time will your name be identified; your answers are never identified with your name. Please do not write your name on the questionnaire.

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[please note that the copyright is for the entire instrument]

APPENDIX G

Completed Judgements About Nursing Decisions

Appendix G

Completed Judgements About Nursing Decisions

Sample Question

Nurse X was taking care of Mr. Y in a community geriatric facility, where he was on medication for his arthritis. In the course of taking a nursing history Nurse X discovered that the patient has a history of an old ulcer and has been occasionally bleeding from it. The nurse subsequently found this documented in the chart too. Mr. Y was on medications for his arthritis that were contraindicated for ulcer conditions. She brought this to the attention of the head nurse who said she would take care of it; later in the day the head nurse talked to the physician, who was semi-retired and part-owner of the facility. The physician responded by saying not to pursue the matter any further. Nurse X then talked to her supervisor who said that she would not get involved.

We are interested in Nurse X's actions.

For each of the actions listed below, check yes or no: for Column A-whether she should do or not; for Column B-whether she is realistically likely to do or not.

NURSING ACTIONS	Column A		Column B	
	Nurse X <u>should</u>		Nurse X is	
	do:		<u>realistically likely</u> to do:	
	Yes	No	Yes	No
1. Ask for additional order for maalox to cover GI distress.	<u>✓</u>	—	<u>✓</u>	—
2. Forget the whole matter; this battle is not as important as some others that Nurse X cares for.	—	<u>✓</u>	<u>✓</u>	—
3. Talk to her director of Nursing and ask her to intervene; Nurse X tells her director that if the medicine problem is not corrected, she will report the physician to the medical society.	<u>✓</u>	—	—	<u>✓</u>

APPENDIX H

Judgements About Nursing Decisions

Appendix H

Judgements About Nursing Decisions

Nurses A and B Story One

Nurses A and B, good friends, were working the night shift on a Pediatric unit. Johnny, a one year old patient, went into heart failure and was transferred to the ICU. Immediately after the transfer Nurse A told Nurse B that she (Nurse A) had made a medication error and had given Johnny a larger dose of digoxin than was prescribed. She said that she had not reported the error and did not intend to report it; she made it clear that she did not want Nurse B to say anything about it either. She said that she was talking to Nurse B in confidence and that it would be unethical for Nurse B to break this confidence.

We are interested in Nurse B's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

	Column A		Column B	
	Nurse B <u>should</u>		Nurse B is	
NURSING ACTIONS	do:		<u>realistically likely</u> to do:	
	Yes	No	Yes	No
1. If nurse A is basically a competent nurse, this one error can be overlooked; in that case, Nurse B will not do anything.	___	___	___	___
2. Nurse B explains to Nurse A the meaning of professional responsibility and accountability and suggests that she immediately report the error to the ICU staff and Johnny's physician.	___	___	___	___
3. After Nurse A states she will do nothing Nurse B calls the ICU anonymously. She tells of the overdose, and hangs up.	___	___	___	___
4. Nurse B discusses the matter with the charge nurse and seeks advice as to what she should do.	___	___	___	___

5. Nurse B explains to Nurse A that when a patient's life is endangered, information on a drug overdose cannot be considered confidential.

6. Nurse B examines the chart for drug dose recorded, and for other relevant facts, so that she can evaluate the gravity of the error.

COMMENTS:

The Nephrologist and Nurse M Story Two

Dr. Z, the chief nephrologist of a community hospital, constantly makes round on the dialysis unit visibly intoxicated, appearing dirty and disorganized. His speech is frequently slurred and inappropriate. His responsibilities include diagnosing patients and checking the patients on the unit for infection. Nurse M, a staff nurse has noticed Dr. Z's behavior for a period of time and has approached both the head nurse of the unit and Dr. Z's partner to express her concern. She was told by both of them to mind her own business.

Nurse M has three school age children and she is the sole support of her family. She lives in a small close-knit community and is aware that Dr. Z and his wife are good friends with the Director of Nursing and her husband. The community hospital where Nurse M works is the only agency where she can work within a 75-mile radius.

We are interested in Nurse M's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS	Column A		Column B	
	Nurse M <u>should</u>		Nurse M is	
	do:		<u>realistically</u>	<u>likely</u> to do:
	Yes	No	Yes	No
1. Call her professional organization to discuss her concerns and seek advice.	___	___	___	___
2. Write a factual letter to the medical board of the institution.	___	___	___	___
3. Request a transfer from the dialysis unit.	___	___	___	___
4. She need do nothing; it is not Nurse M's responsibility to "clean up" medical practice.	___	___	___	___
5. Write an anonymous and angry letter to the local medical society complaining about Dr. Z's behavior.	___	___	___	___
6. Encourage the patients to complain to Dr. Z and his partner about Dr. Z's behavior.	___	___	___	___
7. Speak to Dr. Z privately and express concern about his health patient safety.	___	___	___	___
<u>COMMENTS:</u>	63			

Mrs. J and Nurse D Story Three

Mr. J has been in ICU for a total of 11 days and comatose for the past seven days. His family was allowed to visit him only for short periods of time. His vital signs faltered and emergency treatment measures were stepped up, to no avail. A few minutes later Mrs. J arrived and was informed of her husband's death by an intern on duty. The intern then immediately asked Mrs. J to sign a permit authorizing an autopsy. She refused. The chief resident then tried to convince her that the autopsy would aid medical science and pressed further for her permission. However, she continued to refuse. The attending physician stepped in and also pressed her to sign the autopsy permit. Mrs. J replied that she wanted her husband to have the dignity she felt he was denied in his last few days in ICU. Mrs J then asked to talk privately to Nurse D who had taken care of Mr. J during the last several days of his life.

The nurse felt the need to support Mrs.J in her refusal to sign the consent form because she viewed her professional responsibility to be toward the patient and his family. She also realized that an autopsy was against the J family's basic beliefs. On the other hand, the nurse, as a professional, is not against having autopsies performed because they are of value in research.

We are interested in Nurse D's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS	Column A		Column B	
	Nurse D <u>should</u>		Nurse D is	
	do:		<u>realistically</u>	<u>likely to do:</u>
	Yes	No	Yes	No
1. Explain to Mrs. J why an autopsy is important and suggest she discuss the matter with her family before making a decision.	___	___	___	___
2. Suggest to Mrs. J that the doctors worked very hard on her husband and that they deserve to do the autopsy.	___	___	___	___
3. Suggest that Mrs. J discuss the matter with the hospital chaplain and offer to call the chaplain.	___	___	___	___
4. Allow Mrs. J to discuss how she feels about consenting and explore her reasons. Whatever decision Mrs. J finally makes, the nurse supports.	___	___	___	___

Story Three Continued

NURSING ACTIONS	Column A Nurse D <u>should</u> do:		Column B Nurse D is <u>realistically</u> <u>likely</u> to do:	
	Yes	No	Yes	No
5. Contact the nursing supervisor and let her talk to Mrs. J.____		_____	_____	_____
6. Suggest to Mrs. J that if the autopsy is performed Mr. J's death will not have been in vain in that it may help other people.____		_____	_____	_____
7. Tell Mrs. J that she (Nurse D) finds herself in conflict. She feels supportive of Mrs. J but also thinks there is merit in allowing an autopsy. _____	_____	_____	_____	_____

COMMENTS:

Mr. G and Nurse H Story Four

Mr. G has had cancer for some time; he has been aware of his diagnosis and was dealing with it quite well. Mr. G was admitted to the hospital for recurrence of cancer.

The physician in charge wanted to test an experimental cancer drug on Mr. G and was trying to convince Mr. G that he would be helped by the "new drug." The nursing and medical staffs on the unit knew that Mr. G's questions were not answered truthfully by his physician. They also knew that this physician's prime interest was to test the drug through further research, and he was intent on getting Mr. G. as a subject, through whatever means.

Mr. G was being asked to sign a consent form, and while he was not fully informed as to what this meant, because of his prior trust in his physician and his fear that saying no would put his care in jeopardy, he was considering signing it. He shared these thoughts with his nurse (Nurse H), and asked questions about the drug and what she thought he ought to do.

We are interested in Nurse H's actions

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS	Column A		Column B	
	Nurse H <u>should</u>		Nurse H is	
	do:		<u>realistically</u> <u>likely to do:</u>	
	Yes	No	Yes	No
1. Contact her head nurse and supervisor and discuss her concern that an experimental drug may be given without a patient's informed consent.	—	—	—	—
2. Reassure Mr. G that his physician has the situation under control and is acting in his best interest.	—	—	—	—
3. Contact the chairperson of the research committee of the institution and alert him that an experimental drug may be given without the patient's full understanding and informed consent.	—	—	—	—

Story Four Continued

NURSING ACTIONS	Column A		Column B	
	Nurse H <u>should</u> do:		Nurse H is <u>realistically</u> <u>likely</u> to do:	
	Yes	No	Yes	No
4. Suggest that she will arrange a meeting involving the patient, the physician and herself so that Mr. G can have his questions answered. She subsequently calls the physician and arranges such a meeting.	—	—	—	—
5. Tell Mr. G. that he is going to get better with the drug and to stop worrying.	—	—	—	—
6. Write an anonymous letter to the research committee of the institution complaining that Mr. G's physician is coercing Mr. G to consent to an experimental drug without fully informing him about it.	—	—	—	—

COMMENTS:

Katie and Nurse P Story Five

It was a holiday weekend on a fairly busy 30-bed pediatric ward with several recent post-op and acutely ill patients. Two registered nurses and one aide were on duty. Everything was under control until 6-year old Katie was admitted as an emergency. She had severe head trauma and required neurological checks every 15 minutes. Katie's parents were with her, visibly anxious about her.

The nurse in charge, Nurse P, assessed the unit to be dangerously understaffed and felt that additional coverage would be necessary to safeguard the patient's life. Nurse P called several staff members who were off duty, but no one was available to come in and work on the unit at that time. This was not the first time that short staffing had caused an unsafe situation.

We are interested in Nurse P's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS	Column A Nurse P <u>should</u> do:		Column B Nurse P is <u>realistically</u> <u>likely</u> to do:	
	Yes	No	Yes	No
1. Notify the resident that due to Katie's condition and low staff-patient ratio it would be advisable to move Katie to the Pediatric ICU.	___	___	___	___
2. Tell the parents, "If Katie were my child, I wouldn't leave her here."	___	___	___	___
3. Tell the supervisor that the situation is impossible and that she (Nurse P) is going to go home.	___	___	___	___
4. Rearrange all priorities, deal with the immediate crisis, <u>then</u> write up the situation and send it to the administrator so that this will not occur again.	___	___	___	___
5. Discuss the situation with the supervisor and explore ways in which she may be of assistance, such as by sending a nurse from another unit or by personally helping care of patients.	___	___	___	___

Story Five Continued

NURSING ACTIONS	Column A Nurse P <u>should</u> do:		Column B Nurse P is <u>realistically</u> <u>likely</u> to do:	
	Yes	No	Yes	No
6. Contact the supervisor and inform her that safe care cannot be assured and that she (Nurse P) will not accept any responsibility.	_____	_____	_____	_____

COMMENTS:

Mr. T and Nurse L Story Six

Mr. T, a 72 year old man, was diagnosed as having advanced cancer of the larynx; he is scheduled for surgery which he knows is not curative but which may prolong his life.

Prior to surgery, Mr. T became withdrawn and introspective. He told Nurse L he was not sure he wanted to go through with surgery; that his thoughts were that he had had a satisfying and long life, and felt he could accept death. He asked Nurse L to advise him as to what he should do.

Nurse L finds herself in a conflict. She believes that she must do everything possible to sustain life, but she also feels that patients have a right to make decisions about their own lives.

We are interested in Nurse L's Actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS	Column A Nurse L <u>should</u> do:		Column B Nurse L is <u>realistically</u> <u>likely</u> to do:	
	Yes	No	Yes	No
1. Remove herself from the situation. Ask to have her assignment changed.	___	___	___	___
2. Help Mr. T problem solve, assess his fears and understanding of the implications of having or not having surgery.	___	___	___	___
3. Support Mr. T in whatever decision he makes.	___	___	___	___
4. Tell Mr. T he should have the surgery.	___	___	___	___
5. Talk to Mr. T's family members and ask them to convince him to have surgery.	___	___	___	___
6. Acknowledge Mr. T's right to decide either way, as well as his right to change his mind later. Assure Mr. T that care will be available to him in either case.	___	___	___	___
7. Suggest a conference with Mr. T, his family, herself and the physician to discuss the matter.	___	___	___	___
<u>COMMENTS:</u>				

APPENDIX I

Demographic Data Sheet

Appendix I

Demographic Data Sheet

Please circle the appropriate letter in response to the questions below. Do not write your name on this sheet.

1. How many hours per week are you regularly scheduled to work?
 - a. 16 or less
 - b. 17 - 24
 - c. 25 - 32
 - d. 33 - 39
 - e. 40 or above
2. Are you a float nurse?
 - a. yes
 - b. no
3. What gender are you?
 - a. female
 - b. male
4. What is your age?
 - a. 18-25
 - b. 26-35
 - c. 36-45
 - d. 46-56
 - e. 56- and over

5. What is the size of hospital in which you are employed?
 - a. less than 50 beds
 - b. 51-100 beds
 - c. 101-200 beds
 - d. 201-300 beds
 - e. 301-400 beds
 - f. over 400 beds
6. What is the location of the hospital in which you are employed?
 - a. urban
 - b. rural
7. In what clinical area do you practice?
 - a. orthopedics
 - b. oncology
 - c. medical/surgical care
 - d. cardiac care/telemetry
 - e. intensive care
8. How long have you practiced in the area chosen in number 7?
 - a. less than 1 year
 - b. 1 - 5 years
 - c. 6 - 10 years
 - d. 11 - 20 years
 - e. 21 - 30 years
 - f. over 31 years

9. What is your total number of years as a staff nurse?
- a. less than 1 year
 - b. 1 - 5 years
 - c. 6 - 10 years
 - d. 11 - 20 years
 - e. 21 - 30 years
 - f. over 31 years
10. What is the highest level of nursing education you have completed?
- a. Diploma
 - b. Associate Degree in Nursing (A.D.N.)
 - c. Bachelors Degree in Nursing (B.S.N.)
 - d. Masters Degree in Nursing (M.S.N.)
11. Are you currently attending courses toward a higher degree in nursing?
- a. yes
 - b. no
12. If your answer to question number 11 was yes, what degree are you seeking.
- a. A.D.N.
 - b. B.S.N.
 - c. B.A.
 - d. M.A.
 - e. M.S.N.
 - f. Other (please specify) _____.
13. What shift do you work? (Select the best that applies)
- a. 7 am. - 3 pm. or 7 am. - 7 pm.
 - b. 3 pm. - 11 pm.
 - c. 11 pm. - 7 am. or 7 pm. - 7 am.

14. Would you say that you have been faced with an ethical dilemma within the past 3 months in your work setting?

a. yes

b. no

15. If your answer to the above question was yes, please explain.

16. Would you say that you have had a significant life experience that could have contributed to your moral and ethical decision making ability, positive or negative?

17. Do you believe that your nursing education prepared you to address ethical problems in your clinical practice setting?

(Please rank your preparation on the scale provided below by circling the correct number choice)

1-----	2-----	3-----	4-----	5-----
not at	prepared	moderately	prepared	well
all	very	prepared		prepared
prepared	little			

APPENDIX J

Scoring The Judgements About Nursing Decisions



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November 23, 1981

SCORING THE JUDGMENTS ABOUT NURSING DECISIONS

(DRAFT)

A manual for the JAND has not yet been prepared. In response to numerous requests on the part of individuals who wish to use it, I have prepared this material for interim reference by users.

The JAND is now a six-story, self-administered instrument; it yields two scores (Total) for each subject- one score for Column A (normative-should do), one score for Column B (categorical-realistically likely to do).

Scoring is quite simple, and here is how it goes: the "correct" answer (as determined by a panel of expert judges) gets a weight of 1, the incorrect answer, a weight of 0; this is the same for column A and for column B. Sometimes "yes" is correct, sometimes "no" is correct. See below.

<u>Story number</u>	<u>Items where "yes" is correct</u>	<u>Items where "no" is correct</u>
One (6 items)	2, 4, 5, 6	1, 3
Two (7 items)	1, 2, 7	3, 4, 5, 6
Three (7 items)	1, 3, 4, 5, 7	2, 6
Four (6 items)	1, 3, 4	2, 5, 6
Five (6 items)	1, 4, 5	2, 3, 6
Six (7 items)	2, 3, 6, 7	1, 4, 5



A practical note: I have found that the simplest way to go at this is, in the initial coding of the JAND- on fortran sheets and on IBM cards- to punch 1 for yes, 0 for no. Then, in the program, include a RECODE statement, reversing the score for the items listed on previous page where the "no" answer is correct- (0=1) (1=0).

Another thought: Since the items in this tool are not listed or numbered 1-39, but rather, 1-6 or 1-7 for each story, I have kept them that way in the analysis process. I have labeled the stories A, B, C, D, E, F. I have also given a label of SH for column A (stands for should do), and a label of R for column B (stands for realistically likely to do). This way it is at all times easy to identify the column, the story, the item. (Thus, SHA5 refers to column A, story one, item #5; RC2 refers to column B, story three, item #2).

In return for granting permission to investigators to use the JAND, I would like to request a copy of the research report upon completion of a project- both descriptive statistics on the JAND, and any relationships observed with other variables.

For the process of the development of the JAND please refer to my article in the May-June 1981 issue of Nursing Research - even though there is some new information on the reliability and validity of the present version of the JAND, it has not been published yet.

Shake Ketefian

Shake Ketefian, EdD, RN, FAAN
New York University

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