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ETHICAL DECISION MAKING BY HOSPITAL NURSES

by

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DISSERTATION

Submitted to the Graduate School

of Wayne State University

Detroit, Michigan

In partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

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MAJOR: HIGHER EDUCATION

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CHAPTER 1

Introduction

The behavior of the registered nurse confronted with an ethical dilemma is variable. This situation arises because of the lack of clear direction for the nurse. As human beings, nurses are socialized with several sets of general ethical guidlines which may be in conflict. The nurse's personal value system, the professional value system and the employer (institutional) value systems are potentially three sets of ethical guidelines which influence the nurse's behavior. Each of these systems frequently conflicts with the others.

The professional code for nurses is the American Nurses Association (ANA) Code for Nurses (1976). The introduction to the Code describes the personal obligation of the nurse to behave in conformance with its tenets, and to insure that other nurses do so as well. It is explicitly stated in the Code that the nurse is personally responsible for the behavior of others who practice as registered nurses. Davis and Aroskar (1978) and Castles (1978) concur with this.

In discussing the professional Code for Nurses, Castles (1978) states that personal values impinge on patient care activities and she thinks there is an accepted myth that only professional values are used in decision making about patient care by the culturally diverse population of registered nurses. She concludes that other value systems

which may be used by the nurse in decision making about patient care remain covert and unexamined. Members of the professional group ought to be expected to behave in conformance with the Code. To date, there has been no substantive research which examines Code congruent behaviors in practicing registered nurses thus, the major thrust for this research project has been to investigate ethical decisions in the presence of hypothetical patient care situations of registered staff nurses practicing full time in hospital in-patient settings.

Davis and Aroskar (1978) conclude that the nurse is powerless to act in conformance with the professional value system (that is, the Code) because of the rules and regulations (value system) of the hospital health care system. Their discussion suggests that the professional role of the nurse in decision making about patient care is not respected in hospitals. It is clear that nurses who are respected and advance in the hospital system are those who comply with with hospital rules and regulations in clinical situations (see, for instance, Kramer, 1974). Systematic examination of the relationship between ethical decision making and perceived powerlessness of the nurse is being studied for the first time in this project, although a previous study (Ketefian, 1985) has examined the relationship between professional and bureaucratic role conceptions and ethical decision making by nurses.

It is generally recognized that in service professions

is is unfair to impose values on the client. However, it is quite clear that nurses' decisions are influenced by several competing value systems including personal, professional and institutional value systems as well as client value systems. This research project was undertaken to identify whether the professional value system and its requirement that client values be protected is the value system used by staff registered nurses employed in in-patient settings as the basis for ethical decision making, or if not, which competing value system influences those ethical decisions.

Now that this information is known, consumers of nursing care can be apprised of the degree of support for their values they can anticipate from nurses. An example of a situation where the client will wish to have this information is the patient with terminal cancer who may decide to remain out of the hospital, or seek alternative health care such as hospice if the client is aware that the nurse will not support his/her value of death with dignity.

Nurses are struggling to be identified as professional by the community of health care consumers. A clear criterion for a profession is that members of the professional group must act in conformance with a code of ethics (Cullen, 1978). Research by Cox (1982) suggests that nurses are unaware of the Code and are not practicing in conformance with it. Other researchers (Ketefian, 1981; Crisham, 1980, 1981) have generalized that this is due to influences of the hospital value system. Those research

studies confirm the results of the Cox study, that nurses are unaware of the Code or the importance of practicing in conformance with it. The study being reported here empirically tests the inferences of Ketefian and Crisham that the failure of nurses to practice in conformance with the Code may be due to the nurse's feelings of powerlessness in the hospital system.

The research being reported here has explored the relationships between nurses' demographic variables, personal values, perceived powerlessness in the hospital and self-reported behavior in the presence of hypothetical ethical dilemmas. The dissemination of these, the findings of this research, will apprise nurses of the status of meeting the criteria of a profession; behavior of members of the profession in conformance with a professional code of ethics.

This research has also indentified variables which influence nurses as they attempt to support client values. Consumers of nursing care will wish to have this information, as changes in hospital reimbursement systems influence the type of care a client can receive. This information may also be useful to nursing service administrators by making the perceived powerlessness of nurses in the hospital system known, thereby improving working conditions for nurses in hospitals. Nursing service administrators may also be able to make some inferences from this study regarding the relationship between nurses perceived powerlessness, ethical

decision making and quality of nursing care services although the totality of the relationship has not been explored. The ANA may also be able to use the results of this study in reformulating the Code so that it is easily applicable in the hospital health care setting. Finally this research is the foundation for further research identifying variables which contribute to excellence in ethical decision making. When fully identified these variables may be usful in selection of students for professional education programs in nursing.

CHAPTER 2

Review of the Literature

Nurses face ethical dilemmas daily. Davis and Aroskar
(1978) address client's rights and obligations; abortion;
death and dying; mental retardation and public policy; and
allocation of scarce health care resources as the topics
which generate ethical dilemmas for nurses. This list, while
not exhaustive, identifies a set of topics of growing concern
to nurses and the ubiquitousness of ethical dilemmas in
nursing practice. Nursing's professional values for dealing
with ethical dilemmas are expressed in the ANA Code for
Nurses (1976). A copy of the Code appears in Appendix A.

Opinions of Experts about the Code

The explicitness of the Code gives clients and other
health care workers possible expectations concerning the
ethical behavior of nurses. These expectations, however, may
not be met since experts in nursing ethics (Murphy and
Murphy, 1976; Thompson and Thompson, 1979; and Curtin, 1978)
propose that personal values should be the primary basis for
ethical decision making. Levine (1977) calls the imposition
of personal values on a client a "moral injustice" (p. 845)
because the ethical, religious, social and cultural plurality
in this country supports a wide range of value systems and
the Code specifically prohibits it.

The implementation of the Code in the hospital settting may present problems for nurses. The first item in the Code states that the nurse "provides services with respect for human worth and dignity and is repectful of the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes or the nature of the health problem." The right to self-determination; the right to quality care; the right to respect for human worth and dignity; the right to non-prejudicial care; and the right to have one's values protected are identified by the interpretive statements of the Code.

The right to self-determination is based on the right to the information necessary to make an informed decision about health care practices. Nurse's cannot inform clients, since the courts have asserted that the physician is responsible for informed consent (Holder and Lewis, 1981). Greenlaw (1980c) analyzed Tuma versus the State Board of Nursing of Idaho, concluding that it is possible for nurses to lose their licenses to practice professional nursing for informing clients, if appropriate criteria are in place at the Board of Nursing. The nurse may not be able to respect the client's right to self-determination given these societal constraints.

The right to quality, non-prejudicial care, regardless of class or culture, is identified in the first Code item along with respect for human worth and dignity, regardless of the health problem. Larson (1977) studied nurses' reactions to high and low socio-economic status clients with socially

acceptable and unacceptable diagnoses. She found that low class clients and those with socially unacceptable diagnoses were negatively stereotyped. Since cultural relativism is a recognized sociological phenomena (Horton and Hunt, 1972; VanDerZanden, 1970) it might be expected that clients of a culture different than the nurse may also be negatively stereotyped. Morimoto (1955) found that nurses approach preferred clients in a personalized way, ministering to physical and psycho-social needs, where nurses approach non-preferred clients in a business like manner ministering to physical needs only. Further Kelley (1965) found that nurses who negatively stereotype clients have restricted interaction with those clients. Clearly research documents that the nurse's perception of the client interferes with the quality of care which the client receives.

The Code expects that all nurses will protect the basic human values of the dying client. The interpretive statements of the Code do not specify which values are basic. Bandman (1978) discusses the options among the moral philosophers concluding that the nurse, working with the dying client, having considered the options, formulates a personal ethical position and protects the values dictated by that position. These personal values may be in conflict with the client's values.

The nurse is supposed to safeguard the client's right to privacy by judiciously protecting confidential information. This item is violated by nurses who discuss clients with

inappropriate personnel and/or in inappropriate places.
Greenlaw (1980a) responds to a nurse's query about nursing
report in the cafeteria by imploring nurses to avoid
discussing clients in public places. In spite of
exhortations to confidentiality in the Nightingale Pledge
(Kelly, 1962) the discussion by Greenlaw supports the
conclusion that this is a frequently violated portion of the
Code.

The nurse is expected to protect the client from
illegal, unethical or incompetent practice by all classes of
health care worker. Greenlaw (1980b) states that nurses have
the legal obligation to control the conduct of another, to
prevent harm to the client, or to warn the client of possible
harm. The American Medical News (September 14, 1979) states
that nurses rarely report physician misconduct, while
Greenlaw (1980b) reports three hundred cases of nurses
reporting nurse's misconduct. It is evident that nurses are
not satisfactorily controlling the conduct of physician
colleagues, but are more adequately supervising the practice
of nurse collegues.

Expert discussion of Code items clearly shows that they
are not easily applicable in the hospital nursing setting.
Bandman (1978) infers that the ethical nurse caring for a
client is often removed when the nurse attempts to support
the client's value system (for example, the living will) and
is replaced by a nurse who is willing to support hospital
values. Stanley's discussion (1979) supports this inference.

Cox (1982) examined the ethical decisions made by a random sample of registered nurses in Michigan. In his study few nurses report using the Code as the primary basis for ethical behavior. It is clear from the results of his study that some covert and unexamined value system other than the Code is the foundation for ethical behavior. Professional values are, however, useless unless they change the behavior of the nurse, and provide a legitimate power base for nurses in employment situations.

Related Research

The theory of bureaucratic structures proposed by Weber (1946) is explanatory in this study. Weber states that the rules and regulations (that is, the articulation of the organizational value system) of a bureaucratic structure are difficult to change because of the complexity of the organization. He states that employees in a bureaucractic organization, such as a hospital, are valued if they conform to the rules and regulations of the system. It is clear that when a discrepancy between professional values and hospital rules and regulations exists the nurse is in a powerless position. Behavior by the nurse in conformance with the professional value system might result in loss of job, income, security and status. This has lead Maurice and Warrick (1979) to conclude that nurses do not retaliate against the rules and regulations of the hospital

bureaucracy, even though they are detrimental to client care, because the system is seen as all powerful in the allocation of rewards. Ashley (1976) has documented that nurses employed in hospitals are powerless.

Benne and Bennis (1959) examined role confusion and conflict in registered nurses. In their research of nurses employed in out-patient departments, they found that the greatest source of conflict was between staff and supervisors. They further found that if the supervisor was seen as having the authority to influence the rewards the nurse received, the supervisor's influence on the nurse's behavior was greater. Their conclusions however, were that the greatest rewards for nurses were factors which the supervisor does not directly control, except by termination of the employment situation.

Aiken and Hage (1966) examined organizational alienation among professionals employed in 16 social welfare agencies. They defined alienation as sense of disappointment with the work setting and a feeling of powerlessness over the work. They found that workers in these organizations who had advanced training and had adopted a code for professional behavior in agencies with a high degree of bureaucratization were alienated from work and expressive relations. It was also found that lack of participation in decision making is related to work alienation. Further, they found that when rule observation was high there was a strongly positive relationship between alienation from work and alienation from

expressive relationships. It is clear from their study that perceived powerlessness in the bureaucratic organization influences job satisfaction in service settings. Direct comparisons are possible with professional nurses employed in hospital settings. If the nurse is given autonomy to perform the job in the most efficient way, the nurse will feel less work alienation and alienation from expressive relations. There is no documentation which predicts the influence of professional autonomy on quality of client care in nursing but it can be inferred that if alienation is lessened quality of care will increase.

Hall (1968) examined the relationships between professionalization and bureaucratization. In his study several occupational groups, including nurses, were examined. Hall classified occupations into autonomous, heteronomous and departmental. In the autonomous organization, the professionals themselves are the major determinants of the structure. In the heteronomous organization, the control of the organization by professionals is lost to external controls. In the departmental structure, control over the work is mainly a function of the bureacracy. Hall found that nurses practiced in heteronomous organizations. Hall's data support the conclusion that nurses have little professional autonomy in highly bureaucratic organizations.

Scott (1965) examined the reactions of social workers to supervision in heteronomous professional organizations. In his study the supervisors all held graduate degrees in social

work, and the workers, were mostly baccalaureates. Some workers however, did not have a baccalaureate degree and some had taken graduate courses in social work. Scott's description of educational preparation for practice is not comparable with nursing, since there are three entry levels qualifying graduates to practice as registered nurses (associate degree, diploma in nursing and baccalaureate degree in nursing). Further in his study there is promotion to supervision based on preparation for practice through advanced study. This is a situation which does not occur in nursing, since historically nurses advance in the system based on seniority and compliance with hospital rules and regulations (although there is some evidence that in larger centers this is changing). The data show that supervisors in this agency were most effective when seen as competent professionals, serving as resources to the workers rather than as bureaucrats who adhered to the rules and regulations of the organization.

Engel (1970) studied physicians hypothesizing that as the degree of bureaucracy increased, professional autonomy would decrease. Her sample consisted of physicians in independent practice, in group practice and in a governmentally associated medical organization. She found that physicians in group practice (moderate bureaucracy) were most likely to perceive themselves as having more autonomy over clinical practice and research than those in private practice (low bureaucracy) and in the governmentally

associated medical group (high bureaucracy). She concludes
that the professional bureaucracy which supplies the

professionals with funds, equipment, support personnel and
physical facilities necessary to carry on the work may not be
detrimental to professional autonomy. This type of
professional bureaucracy is not present in nursing services
in hospitals. Meisenhelder (1982) describes the situation
accurately when she states:

> Nurses are plagued by the same ailments that
> managerial women are: sexual discrimination and sex
> role socialization. America's long history of
> sexual discrimination continues to rob nurses of
> power and influence in the health care system.
> Nursing is oppressed by male dominated medicine and
> hospital administration, which frequently dictate
> nurses' role, status and most importantly salary.
> Nursings' only hope for survival as a profession is
> to gain policy and decision making influence within
> this system.
>   How does this oppression affect staff nurses?
> Too often they are unable to fulfill their own role
> expectations or to use the knowledge and skills
> acquired in their professional education. They are
> underpaid and burdened with unreasonable working
> conditions. Nurses are given the responsibility
> for delivering quality care without the authority
> to decide staffing needs, budget allocations,
> equipment and supply purchases or roles of
> auxiliary personnel. When individuals are fenced
> in to such a restricted role, and one that is far
> below their capability, their response is that of a
> caged animal. Apathy, boredom and a decreased
> sense of self-worth become common elements in the
> grass roots segment of nursing.

This discussion clearly shows that the situation in which
nurses are employed is not a moderate bureaucracy. Nurses
have very little control in the hospital over supplies,
equipment, staffing needs or support personnel and thus
develop a feeling of powerlessness in the system.

Pearlin (1962) studied the structural properties of a mental hospital and their relationship to nurse alienation. He defines alienation as a feeling of powerlessness over one's own affairs. He found that alienation is most likely to occur when authority figures and subjects are in relations of great positional disparity, where authority is communicated in a way to prevent or discourage discussion and where the authority exercises authority in relative absentia. In nursing today, physicians perceive authority over the nurse with several layers of management between the nurse and the physician. This claim to authority is supported by hospital administration and is particularly true in team nursing settings where the staff registered nurse reports to a team leader who reports to the head nurse, who reports to the first year resident and so on until the attending physician is informed of the staff nurse's concern.

Corwin (1961) studied student nurses, graduate nurses and head nurses to ascertain professional-bureaucratic conflict. He states that at graduation the student becomes an employee of the hospital and thus must struggle to resolve the conflict present between hospital realities and the idealism presented by teachers of nursing, who are removed from clinical nursing practice. He found that nurses with high professional orientations experienced great conflict in the hospital setting, if they attempt to also be loyal to the bureaucratic structure. His results are predictable in that he found that degree (baccalaureate) prepared nurses had

higher professional loyalty than diploma graduates. He found that diploma graduates were more likely to have low professional orientation and high bureaucratic orientation.

Johnson (1971) examined the professional-bureaucratic conflict felt by head nurses and supervisors. Her findings indicate that head nurses and supervisors generally feel conflict between professional values and bureaucratic values. She concludes "...it seems clear that hospital organizational structures are not designed to allow professional functioning." She does state that all the supervisors in the study were diploma prepared which means that they may have a higher bureaucratic orientation than degree nurses and may be a source of contamination for her study.

Swider, McElmurry and Yarling (1985) examined ethical decision making in a bureaucratic context by nursing students. For all types of nursing students, decisions were made which conform to bureaucratic norms. It is clear from their study that professional considerations are secondary to bureaucratic considerations when making ethical decisions, thus suppporting the conclusion that the influence of the hospital system on decision making is significant.

Ketefian (1985) examined the influence of professional and bureaucratic role conceptions of registered nurses on moral behavior. In her study she used registered nurses at all levels in the hospital hierarchy from staff nurse to nursing supervisor. She posited that the Code ought to be the primary basis for ethical decision making by registered

nurses. She divided the scores on the predictor variables into normative, categorical and discrepancy scores for professional and bureacratic role conceptions. From the research report, it is unclear how these scores were obtained or the significance of the scores to the total project.

Ketefian's results show that statistically significant relationships exist between professional normative, professional categorical and professional role discrepancy with moral behavior and bureacratic role discrepancy with moral behavior. She concludes that high professional role orientation is a good predictor of moral behavior in congruence with the Code. This is a personal characteristic of the nurse which may predict nurses behavior in hypothetical clinical situations. However in her study there is no documentation of the nurse's perceived power to implement the decision in the clinical setting.

Festinger's (1957) cognitive dissonance theory is also explanatory in this study. Festinger described dissonance as the opposition of two cognitive elements. Three concepts are central to his theory. The first concept is definition of relationships; the second, intensity of dissonance and the third, dissonance reduction.

Festinger classifies relationships between two elements as either consonant, irrelevant or dissonant. Consonant relationships are those in which there is agreement between the two sets of data. A fairly typical consonant relationship arises when a nurse, caring for her abortion

clients, considers abortion to be a personal decision.

An irrelevant relationship is one in which the characteristics of the two sets are not related. A fairly typical example of an irrelevant relationship occurs when the nurse works in a nursing home and considers abortion to be a private decision. In this example, the nurse will never be required to care for a client undergoing therapeutic abortion and thus there is no relationship between the two value sets.

A dissonant relationship is one where there is conflict between two competing sets of values or behaviors. A fairly typical dissonant relationship occurs when the nurse, caring for her abortion clients, believes abortion to be murder. In this case, the nurse's values are in direct conflict with her behavior and the stage for cognitive dissonance is set.

Festinger develops the concepts of dissonance intensity and dissonance reduction. He states that the intensity of the dissonance is directly proportional to the importance of the elements in the dissonant relationship. Using the previous example of a dissonant relationship, the dissonance would not be as great if the nurse were unsure of her personal values, if the nurse refused to care for the abortion clients, or if the nurse worked on another unit in the same institution where abortion clients were not admitted.

He also states that dissonance causes pressure to reduce or eliminate the dissonance. The strength of this pressure is a function of the intensity of the dissonance. Reduction

of dissonance may be accomplished by changing one or more of the elements in the dissonant relationship; by adding new cognitive data consonant with existing cognitive elements or by decreasing the importance of one or more of the elements in the dissonant relationship. In the previous example of a dissonant relationship, the nurse might change jobs to a unit where abortion clients are not routinely admitted, might research relationships between unwanted children and child abuse concluding that therapeutic abortion is good, or might decrease the importance of her role by believing that its only a job and someone has to do it.

When the nurse is in a state of cognitive dissonance, the nurse's behavior in the clinical setting is dissonant with the learned professional values. A single exposure to a dissonant element is usually not a strong enough stimulus to create a high degree of dissonance. As the situation repeats itself over time, as will occur in the clinical nursing setting, the intensity of the dissonance will increase to a level where reduction of dissonance becomes necessary.

Learning is generally considered to affect attitudes during the basic educational process, thus bringing the student's personal ethic into a consonant relationship with the professional ethic. However, the professional ethic is not easily applicable in the clinical nursing setting, thus the stage for cognitive dissonance is set. Corwin (1961) and Kramer (1974) both document this phenomena, although they do not identify it as cognitive dissonance.

The approach used to reduce the dissonance will be a function of the attractiveness of the alternatives. The nurse may change the ethical Code, however, changing the professional code is not a viable short term option, and may not be a viable long term option. Thus the nurse may select another alternative. Withdrawing from the setting may only temporarily reduce the dissonance as ethical dilemmas are ubiquitous in clinical nursing settings. This nurse may become the one whom Kramer (1974) refers to as the "job-hopper." Gathering more data may not effectively reduce the dissonance, in fact in may increase the dissonance and is probably not a viable alternative. Finally, the nurse may decrease the importance of the professional Code.

Discarding the professional value system learned in the basic nursing education program is the least traumatic alternative to select for the reduction of dissonance, as the other alternatives involve either attempting to change a bureaucratic value system or an impossible mobility. The concept of the ivory tower of academia is not new or unheard of in clinical nursing practice (Kramer, 1974). Thus, the nurse in a state of cognitive dissonance who hears colleagues criticizing nursing education, can easily selectively discard learned concepts and values taught by nurse educators as impractical and unrealistic. The nurse may try the other alternatives such as writing to the professional association about the realities of the Code, leaving the job setting (once or several times) or gathering more data, none of which

will effectively relieve cognitive dissonance. The work done by Kramer (1974) clearly shows that new graduate nurses do selectively discard practice values. There is no research which lends support for the conclusion that this may also occur in ethics.

The work by Kohlberg (1964, 1969, 1976) also has explanatory value in this study. Kohlberg has theorized that moral development progresses along defined cognitive pathways. Central to his theory are the assumptions that (a) each stage of moral development is an integrated whole, (b) a particular stage is seen as being integrated into the next stage and finally replaced by it, (c) each individual actively works out his/her moral synthesis and does not merely adopt a synthesis provided by people external to him/her and (d) the individual must pass through previous stages before moving on to the next stage; therefore the order of sucession of stages is constant and universal.

Bouhmama (1984) summarizes Kohlberg's levels and stages as follows:

Level 1: Preconventional Morality

    Stage 1: Punishment and obedience orientation

    Stage 2: Naive instrumental hedonism

Level 2: Conventional Morality

    Stage 3: Good boy morality of maintaining good

           relations, approval of others

    Stage 4: Authority, rule and order maintaining

           morality.

Level 3: Postconventional morality.

  Stage 5: Morality of contract, of individual rights

          and democratically accepted law.

  Stage 6: Morality of individual principles of

          conscience.

Kohlberg's framework is not without criticism. Kurtines
and Grief (1974) surveyed the literature on moral development
concluding that the stages proposed by Kohlberg may reflect
actual development however the general lack of evidence
reflects the inadequacy of the measuring device used to
assess the stages of moral reasoning. Further Bouhmama
(1984) conducted a cross cultural study using Kohlberg's
framework finding significant differences between the two
groups. However, in Bouhmama's study there were no
differences within groups between males and females.
Gilligan (1982) however, has postulated that Kohlberg's basic
assumptions are incorrect because of the methodological error
of observing only male subjects. Regardless of the outcomes
of the debate of Kohlberg's moral development theory, there
are useful concepts contained therein for this study.

Rest (1975a, 1975b, 1976a and 1976b) developed an
instrument which measures moral development using the
Kohlberg model on a paper and pencil test. Inherent in this
instrument are none of the methodological errors common in
the Kohlberg instrument. Thus the reliability of this
instrument is not in question. The research using the

Defining Issues test has clearly shown that education is the
single greatest predictor of moral level (see also,
Dortzbach, 1975; Coder, 1976; Ernsberger, 1977; Bloom, 1975
and Ismail, 1976). Edgil (1980) used the Defining Issues
Test with student nurses, and Ketefian (1981) used it with
registered nurses with the same results.

Crisham (1980, 1981) used the Defining Issues Test to
develop the Nursing Dilemmas Test. In her research, Crisham
developed a test for nurses which presents dilemmas common in
nursing practice. This test has been found to be reliable
and valid in assessing the moral level of nurses on a
Kohlberg-like scale and is related to the moral level found
on the Defining Issues Test. Crisham also found that
education is the single greatest predictor of moral level.

Ketefian (1981) also studied critical thinking in
registered nurses. The findings were consistent. Critical
thinking is at a higher level as educational preparation for
nursing practice advanced. Crisham and Ketefian both think
that critical thinking and moral decision making ought to be
higher in health care systems. Crisham questions whether the
bureacratic structure of the hospital health care system does
not allow nurses to use this increased level of critical
thinking and moral decision making.

CHAPTER 3

Design

This study has investigated the relationship between the
professional nurse's sense of powerlessness as a result of
the official rules and regulations of employing hospitals on
the one hand and the expectations established by the ANA Code
for Nurses on the other. Primary data for the study are
nurses' responses on the Nursing Dilemmas Test, the Ethical
Behavior Inventory and the Health Care Work Powerlessness
Scale. An additional source of data, gathered for
interpretive value, is the Demographic Data Inventory
developed by the writer.

Major Research Questions

There are four major questions which this research
attempted to answer:

Is there a relationship between the nurse's

perceived powerlessness and the nurse's self

reported behavior in the presence of hypothetical

dilemmas, as measured by the Health Care Work

Powerlessness Scale and the Ethical Behavior

Inventory?

Is there a relationship between the nurse's moral

level and the nurse's self reported behavior when

confronted with hypothetical dilemmas as measured
by the Nursing Dilemmas Test and the Ethical
Behavior Inventory?

Is there a relationship between the nurse's moral
level and perceived powerlessness as measured by
the Nursing Dilemmas Test and the Health Care Work
Powerlessness Scale

Do relationships exist between demographic
variables and the nurse's self reported behavior in
the presence of hypothetical ethical dilemmas as
measured by the Demographic Data Inventory and the
Ethical Behavior Inventory?

Operational Definitions

Institutional Values: The rules and regulations of the
hospital in which the nurse is employed.

Professional Values: The standards which are articulated in
the ANA Code for Nurses.

Personal Values: Standards of conduct held and observed by
individuals, independently of official codes or regulations.

Sample and Data Collection

The sample studied consists of 231 registered nurses in staff positions in five hospitals. Those hospitals were: a 100 bed inner-city hospital (Hospital A); a 100 bed rural hospital (Hospital B); a 250 bed medical school affiliated general hospital (Hospital C); a 280 bed university affiliated general hospital affiliated with a large medical center (Hospital D); and a 500 bed, urban, Roman Catholic, teaching hospital (Hospital E). These five hospitals were approached because it was assumed that they represented the general population of hospitals, although no attempt was made to randomly select or standardize the hospitals selected. The hospitals were all located in Southeastern Michigan or Northwestern Ohio. All approached hospitals sanctioned the conduct of the study in the hospital.

Through the cooperation of supervisory personnel, mutually agreeable times were established to meet with each of the nurses to explain the purposes of the study and the nature of the questionnaire. The investigator arrived on each unit at the established date and time, approaching the nurses. This individual approach was used, although it was time consuming, so that each nurse had the opportunity to see the investigator and thus be able to make a personal commitment to complete the questionnaire. At this individual meeting, potential subjects were assured of complete confidentiality of their responses and asked to read and sign the consent letter which appears in Appendix B.

If the nurse agreed to be a subject for the study, the nurse was given a packet which contained the demographic data inventory and the instruments to be completed. The subject was also given an addressed envelope to return the questionnaire to the investigator. Reminder letters (see Appendix C) were sent to those who agreed to participate in the study and had not completed the questionnaire after two weeks, four weeks and six weeks had elapsed. Eight weeks after the subject had been approached, if the subject had not responded, the subject's consent was destroyed.

When the subject returned the questionnaire, it was checked for completeness. If it was determined that the questionnaire was complete, the random six digit alpha-numeric selected by the subject as a subject number was obliterated from the consent and the questionnaire. Although no questionnaires were incomplete, if there had been incomplete questionnaires they would have been returned to the subject so the subject could complete them. This process resulted in the identification of minimal risk to human subjects, since direct identification was not required and consent to participate could be withdrawn at any time.

In each hospital full time registered staff nurses without supervisory responsibilities were approached on work time and asked to participate in the study. It was the intent to approach all full time staff nurses. However, this was impossible because of days off, sick days, vacations and leaves of absence. Consequently all full time registered

staff nurses working on the days of data collection were approached. In Hospital A, 26 nurses were approached with 1 nurse refusing to participate and a response rate of 24 (96%). In Hospital B, 27 nurses were approached with 2 nurses refusing to participate and a response rate of 12 nurses (48%). In Hospital C, 93 nurses were approached, with 3 nurses refusing to participate and a response rate of 60 nurses (66%). In Hospital D, 102 nurses were approached with 3 nurses refusing to participate and a response rate of 59 nurses (60%). In Hospital E, 133 nurses were approached with 12 nurses refusing to participate and a response rate of 76 nurses (63%).

Description of Instruments

Four instruments were used in the conduct of this study:

1. The Health Care Work Powerlessness Scale
2. The Nursing Dilemmas Test
3. The Ethical Behavior Inventory
4. The Demographic Data Inventory.

The Health Care Work Powerlessness Scale

The Health Care Work Powerlessness Scale (see Appendix G) was developed by Guilbert for her Master's research in 1972. Currently Guilbert is using the instrument in her doctoral dissertation. Content validity has been established by a panel of experts. Reliability studies indicate a split half reliability of 0.70 to 0.80.

Each item in the Powerlessness Scale forces a choice between two statements, one indicating a feeling power, the other powerlessness in the institution. For scoring, each power choice was assigned a zero and each powerlessness choice a one. The score was summed over the 14 items to obtain a powerlessness score. Possible scores range from zero to 14.

The Nursing Dilemmas Test

The Nursing Dilemmas Test (see Appendix D) was developed by Crisham as her doctoral dissertation. It uses six scenarios representing the kinds of ethical problems nurses face. Respondents are asked three questions about each scenario: (A) What should the nurse do?; (B) from a list of six items the nurse should consider, select the most important consideration for the nurse in this situation, the second most important, the third most important, the fourth most important, the fifth most important and the sixth most important; and (C) have you encountered a similar dilemma. The second question, the only one used for data in the present study, gives rise to the Nursing Principled (NP) index, the moral development of nurses on a Kohlberg-like scale. Crisham found the test to be reliable (Cronbach's alpha=0.57) and valid in relation to the Kohlberg-like scale. The present study is concerned only with the Nursing Principled index of the instrument, although a requirement of the permission to use the instrument is that the test had to be used in its entirety and all data obtained be forwarded to

Crisham for continued work on the instrument.

The Nursing Principled score was obtained using Crisham's method. In Part B of the test, the item ranked as most important by the subject was given six points, the item ranked as second was given five points, the items ranked as third was given four points, the item ranked fourth was given three points, the item ranked as fifth was given two points and the item ranked as sixth was given one point. The Nursing Principled Score (NP) was calculated by adding the scores of items that represent stages five and six of moral development. The NP Index represents that sum of weighted ranks given to principled moral considerations in making a moral decision in nursing practice. Possible NP scores range from 0-66 with two nursing principled items for each of six dilemmas.

The Ethical Behavior Inventory

The Ethical Behavior Inventory (see Appendix E) was developed by the researcher. The scenarios presented to the nurse were developed by Crisham as the first level of her dissertation. In the development of the scenarios, Crisham interviewed nurses, asking them to identify common dilemmas in nursing practice. Through her interviews, she identified 21 common dilemmas.

Crisham used six of the identifed dilemmas to construct the NDT. The present researcher used 14 of the remaining 15 dilemmas to construct the Ethical Behaviors Inventory (EBI). One was not used because it was not amenable to the multiple

choice response format.

The researcher rewrote the scenarios so that it would not be obvious to the participating nurses what the Code congruent response was. A multiple-choice test with three or four behavioral responses to each scenario was constructed. One response was Code congruent, the other two or three responses were plausible distractors. For each Code congruent behavior the nurse reported, a score of one was assigned, for each response that was not Code congruent a score of zero was assigned. The scores were then summed over the dilemmas to obtain a Code congruency score.

The Ethical Behavior Inventory was then submitted to two experts in nursing ethics to tentatively establish content validity. These experts were both Doctorally prepared, published in the area of nursing ethics and identified by the ANA as experts in the area of nursing ethics. The experts agreed to content validity.

The Ethical Behavior Inventory was then administered to a group of 49 registered nurses as a pre-test of the instrument to judge reliability. Point bi-serial and Hoyt's reliability of the total test (Rtt) were obtained using the program Lertap. The result of this analysis appears in Table One.

Table One shows that the test was generally reliable. However two items (six and seven) had high percentages correct (96% and 100% respectively) and thus were dropped from analysis because they were not good discriminators. The

ITEM	PER CENT CORRECT	POINT BI-SERIAL
1	78	0.67
2	70	0.86
3	66	0.77
4	70	0.66
5	66	0.87
6	96	0.38
7	100	1.00
8	68	0.74
9	82	0.78
10	80	0.67
11	82	0.67
12	86	0.72
13	78	0.77
14	86	0.56

N=49

Hoyt's Rtt=0.93

Table One: Point Bi-Serial for Pretest when All Items
were Included in Analysis.

ITEM	PER CENT CORRECT	POINT BI-SERIAL
1	78	0.67
2	70	0.86
3	66	0.70
4	70	0.86
5	66	0.87
8	68	0.74
9	82	0.75
10	80	0.64
11	82	0.64
12	86	0.67
13	78	0.76
14	86	0.40

N=49

Hoyt's Rtt=0.93

Table Two: Point Bi-Serial for Pretest when
Non-Reliable Items were Deleted from
Analysis.

data were analyzed·again dropping the two items. The results of this analysis appears in Table Two.

Table Two shows that the Inventory is a reliable test. Point bi-serial for each test item, except item 14, is above 0.60. Item 14 has a point bi-serial correlation of 0.40. The critical value of the bi-serial correlation with 47 degrees of freedom and àlpha=0.01 for a two tailed test is 0.366. Thus all items were used for the test. Further, in this test Hoyt's estimator of reliability is high (0.93). Thus the test is reliable and tentatively valid in assessing the ethical behavior of nurses in hypothetical clinical situations.

The Demographic Data Inventory

The Demographic Data Inventory (see Appendix F) was developed by the investigator. Its purpose was to obtain the demographic characteristics of the subjects. It identified age range, years of experience range, basic and current preparation for nursing practice, religion, basic education in an institution with a religious affiliation, clinical area of practice, membership in the ANA and the subject's value preference in making an ethical decision.

Data Analysis

The variables which were examined are age, years of experience, basic nursing education, basic nursing education in an institution with a religious affiliation, basic nursing

education in a state or territory of the United States, current preparation for nursing practice, clinical area of practice, membership in the ANA, value preference in making ethical decisions, nursing principles score on the Nursing Dilemmas Test, powerlessness score on the Health Care Work Powerlessness Scale and Code congruency score on the Ethical Behavior Inventory. The first ten variables were obtained on the Demographic Data Inventory and are categorical variables. The remaining three variables were obtained from the three tests and are continuous variables.

Continuous variables were examined used the condescriptive and Pearson Correlation techniques in the Statistical Package for the Social Sciences (SPSSx). These procedures revealed mean, standard deviation and Pearson Product Moment Correlation Coefficients (r) between the continuous variables. Frequencies and percentages were used to examine the categorical data.

Continuous variables were then recoded into categorical variables using the SPSSx command recode. The Nursing Principled score was categorized into not post-conventional morality (0-44), and post conventional morality (45-66). The powerlessness score was recoded into low (0-5), and high (6-14). The Code congruency score was recoded into low (0-3), moderate (4-6) and high (7-10).

The categorized and categorical data were then subjected to Chi Square analysis using the SPSSx crosstabulation procedure. This statistical procedure was appropriate in

this study because each frequency entry in the Chi Square table represented a different individual and thus the requirement of independent observations was met (Volicer, 1984). The Chi Square test was used to determine the association of two variables. Chi Square analysis was applicable in this study because the procedure can be extended to compare more than two levels of any variable.

The null hypothesis for Chi Square analysis is always that row and column variables are not associated. The expected values for the Chi Square are computed under the assumption of no association. If the null hypothesis is accepted the observed values closely approximated the expected values and the value of chi square was small. If there was an association between the row and column variables, the null hypothesis was rejected as the observed frequencies were different from the expected frequencies. No directionality is associated with the Chi Square test, since it is a sum of squares. Thus all significant Chi Square values are at one end of the distribution and provide evidence only for the rejection of the null hypothesis. In all analyses, statistical significance was determined at alpha<.05.

CHAPTER 4

Results

Research Hypotheses

There is a relationship between the nurse's perceived powerlessness and the nurse's self reported behavior in the presence of hypothetical dilemmas.

There is a relationship between the nurse's moral level and the nurse's reported behavior when confronted with hypothetical dilemmas.

There is a relationship between the nurse's moral level and perceived powerlessness.

Relationships exist between demographic variables and the nurse's self reported behavior in the presence of hypothetical dilemmas.

Scores Derived from the Tests

On the Nursing Dilemmas Test 56 of the 231 nurses scored in the conventional morality range (23-44), 175 nurses scored in the post conventional morality range (45-66). None fell into the preconventional category (0-22). (See Table Three.) Generally preconventional morality is considered childlike

avoidance of troublesome situations or experiences;
conventional morality is considered adult respect for
authority and social order and post-conventional morality is
considered to be the development of the moral conscience,
replacing social order (what is) with general moral
considerations (what ought to be). The data in this study
indicate that nurses are generally at a high level of moral
development, concerned more with what ought to be than what
is.

The mean of the Health Care Work Powerlessness Scale was
5.394. For convenience, participants were classified as
above the mean if they scored six or higher and below if 5 or
lower. Thus 119 of the 231 nurses were rated low and 112
high on the powerlessness scale. (See Table Four.) There is
no difference between hospitals on the Health Care Work
Powerlessness Scale. It seems reasonable to conclude that
power-powerlessness conflict is present in all hospitals,
although the sources of perceived powerlessness may be
different. Even though a random sample was not used, there
are no data to suggest that the hospitals used for data
collection or the nurses employed in them are different from
the general population of hospitals and staff nurses.

The Ethical Behavior Inventory was used to place the
nurses in three categories for Code congruence. Those
scoring at or below one standard deviation below the mean
(0-3) were rated low. Those score at or above one standard
deviation above the mean (7-10) were rated high.

Consequently, those falling between those two standard deviations (4-6) were rated as moderately congruent. This placed 62, 127 and 42 of the nurses in the low, moderate and high congruence categories respectively. (See Table Five.) This indicates that most nurses are not closely conforming to the tenets of the Code. The mean Code Congruency score is only 4.7 in this sample, identical to the mean in the Cox (1982) study, which uses a similar instrument to the Ethical Behavior Inventory, with the same number of items. However, if nurses were behaving in conformance with the Code, scores would more closely have approximated the maximum score of 12.

Intercomparisons of Test Results

To answer the research questions one, two and three the test data were compared by using the SPSSx command Pearson Correlation for the Nursing Dilemmas Test (NDT), Health Care Work Powerlessness Scale (HCWPS) and Ethical Behavior Inventory (EBI).

Table Six shows that there is no statistically significant relationship between the self-reported behavior of the nurse (EBI score) and Moral level (NDT score, $r=0.696$ $p=.146$), or NDT score and perceived powerlessness (HCWPS score, $r=0.295$, $p=.328$). Thus research questions two and three are answered negatively. There is a statistically significant relationship between perceived powerlessness and self reported behavior ($r=-.1363$, $p=.019$). The results of

Score	Frequency	PerCent
30	1	0.4
32	1	0.4
33	2	1.3
34	1	0.4
36	1	0.4
37	5	2.2
38	2	0.9
39	6	2.6
40	4	1.7
41	3	1.3
42	7	3.0
43	11	4.8
44	11	4.8
45	13	5.6
46	18	7.8
47	24	10.4
48	28	12.1
49	22	9.5
50	18	7.8
51	13	5.6
52	10	4.3
53	7	3.0
54	7	3.0
55	7	3.0
56	5	2.2
57	1	0.4
58	1	0.9

$N=231 \qquad \overline{X}=47.156 \qquad s=5.014$

Table Three: Frequency Distribution of Respondent Scores on the Nursing Dilemmas Test.

Score	Frequency	PerCent
0	26	11.3
1	20	8.7
2	21	9.1
3	14	6.1
4	22	9.5
5	16	6.9
6	20	8.7
7	18	7.8
8	18	7.8
9	15	6.5
10	19	8.2
11	9	3.9
12	10	4.3
13	2	0.9
14	1	0.4

N=231 $\bar{X}$=5.394   s=3.726

Table Four: Frequency Distribution of Perceived
Powerlessness by respondents.

the analysis support the conclusion that as the nurse's perception of powerlessness in the hospital bureaucracy increases the nurse will report behavior which is less congruent with the ANA Code. Thus research question one is answered in the affirmative.

Score	Frequency	PerCent
0	1	0.4
1	10	4.3
2	21	9.1
3	30	13.0
4	40	17.3
5	54	23.4
6	33	14.3
7	20	8.7
8	15	6.5
9	4	1.7
10	3	1.3

N=231 $\overline{X}$=4.754   s=1.985

Table Five: Frequency Distribution of Respondent scores on the Ethical Behavior Inventory.

These findings support the inferences made by Ketefian (1985). In her study, bureaucratic role conception was not as good a predictor of Code Congruent ethical behavior as was professional role conception, whereas in this study, perceived powerlessness of the nurse is negatively related to ethical behavior. Clearly, when these two studies are

examined together, there is support for the conclusion that nurses are in a state of cognitive dissonance when making ethical decisions in nursing practice.

	NDT	HCWPS	EBI
NDT	1.000		
HCWPS	.0295 p=.328	1.000	
EBI	.0696 p=.146	-.1363 p=.019	1.000

Table Six: Correlation Matrix of Nursing Dilemmas Test, Health Care Work Powerlessness Scale and Ethical Behavior Inventory.

Comparisons of the Derived Categories

For the purposes of categorical analyses, the Nursing Dilemmas Test, Ethical Behavior Inventory and Health Care Work Powerlessness Scores were Categorized. On the NDT, nurses who scored 44 or less were categorized as conventional morality, nurses who scored 45 and above were classified as post conventional morality. On the EBI, nurses who scores 0-3 were classified as low Code congruency, nurses who scored 4-6 were classified as moderate Code congruency and 7-10 as high Code Congruency. On the powerlessness scale, nurses who scored 0-5 were classified as low powerless and nurses who scored 6-14 were classified as high powerless.

To answer research question four, the categorized

Ethical Behavior Inventory Score was subjected to the SPSSx

Crosstabs procedure with the categorical, demographic

variables. One statistically significant relationship exists

in these analyses. There is a statistically significant

difference between the scores of nurses who were educated in

the United States and those who were not (χ^2=20.50, df=2.

p<.05). Those nurses who were not educated in the United

States had lower scores on the EBI than U.S. educated nurses.

In this sample, 18 nurses were educated outside of the United

States. See Table Seven. Of the 18 nurses, 13 scored low

Code congruency, four nurses scored moderate Code Congruency

and one nurse scored high Code Congruency.

U.S. Education	Frequency	PerCent
No	18	7.8
Yes	213	92.2
TOTAL	231	100.0

Table Seven: Frequency Distribution of
Respondents by Basic Education in a State or
Territory of the United States.

In this sample 14 (77.7 percent) report education in the

Phillipines, two (11.1 percent) report education in Canada

and two (11.1 percent) report education in other countries.

According to ANA estimates of the population (1983, using

1980 data) 3.7 percent of the registered nurses in the United

States were educated in a foreign country and 96.3 percent

were educated in the U.S.

This difference between this sample and the national population may be accounted for because the inner city hospital used for data collection for many years had a Filipino principal nursing officer and a large population of Filipino nurses. Even though that individual is retired, the repondents from that institution were 66 percent (8) Filipino and 17 percent (2) from other countries. This hospital has traditionally supported minority hiring practices which may explain the discrepancy between the national population and this sample.

In an effort to identify other significant relationships in the obtained data, the demographic variables age, years of experience, basic nursing education, basic nursing education in an institution with a religious affiliation, basic nursing education in a state or territory of the United States, current preparation for nursing practice, clinical practice area, membership in the ANA and value preference in making ethical decisions were submitted to the crosstabulation procedure in SPSSx with the recoded continuous variables NDT score and Health Care Work Powerlessness score. Additional significant relationships were not identified.

Other Demographic Findings

There are several demographic characteristics of the sample which are of interest, even though not significant.

In this study 35.1 percent of the respondents selected personal values as the primary basis for ethical decision making and 42.4 percent selected Standards of Care as the primary basis for ethical decision making. In the Cox study of a random sample of 161 registered nurses licensed to practice in Michigan (1982) 68 percent of the respondents selected personal values and 7 percent selected Standards of Care as the primary basis for ethical decision making. There has been a dramatic shift from the Cox sample, in that in this sample published documents were selected as the primary basis for ethical decision making. These documents are public and open for examination, rather than covert personal values.

The nurses studied here are not meeting the criterion for a profession of behavior in conformance with a professional code of ethics. Only 6.9 percent of the respondents report using the ANA Code as the basis for ethical decision making. In the Cox Study (1982) 6.5 per cent of the sample selected the Code as the primary basis for ethical decision making. Even those who do report using the Code do not have statistically significant higher Code congruency scores (EBI score). This finding is also similar to the findings in the Cox Study.

The nurses in this sample are probably not unaware of the Code. Many schools and colleges of nursing have a course in professional ethics in the curriculum. Every month the American Journal of Nursing has a column on legal and ethical

dilemmas in nursing practice. Conferences on nursing ethics
are frequent. However, these nurses may have been in a state
of cognitive dissonance when attempting to operationalize
Code tenets in the work setting, and thus have minimized the
importance of the Code to ethical decision making or
discarded the tenets as impractical in the hospital
bureaucracy.

The findings in this sample do not support the
conclusions of Rest (1975a, 1975b, 1976a and 1976b),
Dortzbach (1975), Coder (1976), Ernsberger (1977), Bloom
(1975) Ismail (1976), Edgil (1980), Ketefian (1981) or
Chrisham (1980, 1981) that education is related to moral
level. In this sample education is not related to NDT score.
However, this may not be significant since all members of
this sample had at least two years post high school education
and only 24 per cent of the sample could not be classified at
the post conventional level of personal moral decision
making. The failure to have significant findings when
comparing these two variables in this sample may, therefore,
be meaningless.

Additional sample demographics are presented in Appendix
H.

CHAPTER 5

Summary, Conclusions and Recommendations

In this study the behavior of registered nurses confronted with ethical dilemmas has been examined. The ANA Code ought to be the document selected by nurses as the primary basis for ethical decision making. This is not the case in this sample as only 6.9 percent report using the ANA Code as the basis for ethical decision making. This finding is supported by the findings of Cox (1982).

This research project has empirically tested the inferences of Davis and Aroskar (1978), Ketefian (1981, Crisham (1981) and others that the nurse's perceived powerlessness in the bureaucratic structure of the hospital influences the ethical decisions which are made. In this sample there is a statistically significant negative correlation between perceived power of the nurse and ethical decision making. This means that as nurses perceive more powerlessness (less power) there are less decisions in conformance with the Code. It is clear in this sample that there is an association between the hospital value system and the professional ethical decisions made by these nurses.

When sample demographic variables were compared with the measures of powerlessness, no significant relationships were identified. It can reasonably be concluded that in this sample any nurse may feel powerless. Pearlin (1962) studies the factors which contribute to the feeling of powerlessness

(work alienation) in hospitals finding that alienation is most likely to occur when authority figures and subjects are in relations of great positional disparity, where authority is communicated in a way to prevent or discourage discussion or when authority is exercised in relative absentia. In the Aiken and Hage (1966) study it was found that work alienation was high for workers with advanced training in institutions with a high degree of bureaucratization, where there was a lack of participation in decision making and where rule observation was high. While these specific variables related to perceived powerlessness were not studied in this project, it seems reasonable to conclude that one or more of these specific variables may be present in these hospitals, since work alienation (perceived powerlessness) is present to some degree in all hospitals.

When demographic variables were compared with EBI scores, the only significant difference identified was that nurses in this sample that were educated in the United States had higher Code congruency scores than nurses educated outside the United States. For those nursing administrators who are striving for excellence in ethical decision making in their institutions, this finding may have implications for hiring practices and staff development programs. It is recommended that nursing administrators carefully screen applicants of foreign nursing schools to ascertain the types of ethical decisions made and/or provide dynamic staff development programs to those graduates of foreign nursing

programs to socialize them into the values of nurses in the United States.

Because a random sample was not used, no generalizations to the population of nurses employed in staff positions in hospitals can be made. Further, the hospitals used for data collection may not be representative of the general population of hospitals, or the nurses employed in those institutions may not be representative of the population of staff nurses. From the population data available, it is not reasonable to make any conclusions about the representativeness of this sample to the general population of nurses.

Further research on this topic is necessary. The data from this study suggest that nurses may be using the Standards of Care as the primary basis for ethical decision making. Since these values are known, a systematic examination of the content of these documents and their implications for ethical decision making must be made.

Further research to document the phenomena of the association of powerlessness and lower Code congruency scores on the EBI must be done with other samples. The phenomena of bureaucratic and professional role conceptions must also be incorporated into this research so that all the variables germane to the scope of this problem can be identified.

It would also be of interest to conduct further research to identify which of the variables identified by Pearlin (1962) and Aiken and Hage (1966) are contributory to

the perceived powerlessness of nurses in hospitals. These data, when identified, would assist nursing administrators in developing defensible plans to increase the nurse's power in the bureaucratic structure of the hospital.

This research attempted to idenfify variables which contributed to excellence in ethical decision making. When identified these variables may be usful to educational programs in student selection. The variables selected for study were not significant, thus further research in this area is necessary.

APPENDIX A

CODE FOR NURSES

code
for
nurses
with
interpretive
statements

PLEASE NOTE:

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have not been filmed at the request of
the author. They are available for
consultation, however, in the author's
university library.

These consist of pages:

Appendix A, pages 54-73

Appendix G, pages 93-94

APPENDIX B

LETTER OF CONSENT

Medical College of Ohio   School of Nursing

419-381-4172   419-381-3435

3000 Arlington Avenue
Mailing Address: C.S. 10008
Toledo, Ohio 43699

DEAR COLLEAGUE:

YOU ARE INVITED TO PARTICIPATE IN A RESEARCH PROJECT. THE
AIM OF THIS PROJECT IS TO LEARN ABOUT STAFF NURSES' DECISIONS
WHEN CONFRONTED WITH ETHICAL DILEMMAS AND THE FACTORS WHICH
INFLUENCE THOSE DECISIONS. THE GOAL OF THIS PROJECT IS TO
IMPROVE THE WORKING CONDITIONS OF STAFF REGISTERED NURSES.

YOUR PARTICIPATION IN THIS STUDY IS ENTIRELY VOLUNTARY.
RESPONSES WILL BE TABULATED AND REPORTED IN AGGREGATE NUMBERS
ONLY. NO INDIVIDUAL RESPONSES WILL BE REPORTED. YOUR
EMPLOYER HAS SANCTIONED THE CONDUCT OF THIS STUDY IN YOUR
INSTITUTION, YOUR PARTICIPATION WILL NOT AFFECT YOUR
POSITION, STATUS OR EVALUATION. YOUR EMPLOYER WILL NOT HAVE
ACCESS TO INDIVIDUAL RESPONSES.

IF YOU AGREE TO PARTICIPATE IN THIS STUDY, PLEASE COMPLETE
THE QUESTIONNAIRE AND RETURN IT TO ME IN THE ENVELOPE
PROVIDED. PLEASE SIGN THE BOTTOM OF THIS LETTER AS YOUR
CONSENT TO HAVE THE DATA OBTAINED FROM YOU INCLUDED IN THE
FINAL REPORT. ON THE LINE FOR SUBJECT NUMBER, PLEASE SELECT
ANY RANDOM SIX DIGIT COMBINATION OF LETTERS AND NUMBERS,
INCLUDE THIS NUMBER ON THE TOP OF THE DEMOGRAPHIC DATA
INVENTORY. THIS NUMBER WILL BE USED ONLY BY ME TO ASSURE ME
THAT ALL INSTRUMENTS ARE RETURNED AND IF AN INSTRUMENT IS NOT
FULLY COMPLETED, I WILL BE ABLE TO CONTACT YOU.

THANK YOU FOR YOUR ASSISTANCE.

RESPECTFULLY YOURS,

JONATHON L. COX, R.N., M.A., M.S.N.
ASSISTANT PROFESSOR OF NURSING
PRINCIPAL INVESTIGATOR.

SIGNATURE_____

SUBJECT NUMBER_____

APPENDIX C

LETTER OF REMINDER

Medical College of Ohio

School of Nursing

419-381-4172

419-381-3435

3000 Arlington Avenue
Mailing Address: C.S. 10008
Toledo, Ohio 43699

Dear Colleague:

Recently I approached you about being a subject in a research project about the types of decisions nurses make in the presence of dilemmas and the factors which influence those decisions. At that time you agreed to participate. I have not yet received your response to the questionnaire.

I am enclosing another copy of the questionnaire for your use. I will appreciate your responses as soon as possible. If you have decided that you do not wish to participate in this project, please return the questionnaire without answering the questions.

Thank you for your help.

Respectfully yours,

Jonathon L. Cox, R.N., M.A., M.S.N.
Assistant Professor of Nursing
Principal Investigator

APPENDIX D

NURSING DILEMMAS TEST

Nursing Dilemmas

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

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

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

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

Newborn with Anomalies   1

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

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

Should vigorously resuscitate the newborn _____

Can't decide _____

Should not vigorously resuscitate the newborn _____

B.   The nurse considers the following six issues:

1.   Will I be liable to legal action if I let this newborn die?

2.   What specialized neonatal consultation is available?

3.   Who has the right to decide whether this newborn should live or die?

4.   Is it my responsibility to follow the physician's order?

5.   What would be the effect of the birth of this child on the parents?

6.   Should all newborns have the same basic claim on life?

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

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

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

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

Check one response: _____ _____ _____ _____ _____
                         1   2   3   4   5

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

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

Should forcefully give the medication _____

Can't decide _____

Should not forcefully give the medication _____

B.   The nurse considers the following six issues:

1.   What do the other staff nurses on this Unit probably expect me to do?

2.   What will make it easier for me to provide nursing care?

3.   Will I be denying this woman her basic rights if I forcefully give the medication?

4.   How much struggle and noise will occur on the Unit?

5.   Do the current Commitment Regulations permit me to give medication with force to a committed patient?

6.   Was this woman committed according to procedures that were socially equitable?

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

Most Important   _____   Fourth Most Important _____

Second Most Important   _____   Fifth Most Important   _____

Third Most Important   _____   Sixth Most Important   _____

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

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

Check one response: _____ _____ _____ _____ _____
                      1   2   3   4   5

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

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

     Should provide assistance with respirations _____

     Can't decide _____

     Should not provide assistance with respirations _____

B. The nurse considers the following six issues:

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

2. What guidelines are specified in the Unit Manual?

3. Do I have the right to make a decision about an individual's life and death?

4. Is the Hospital Resuscitation Team available for consultation?

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

6. Does the patient have the right to decide about the use of heroic measures?

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

Most Important   _____   Fourth Most Important _____

Second Most Important _____   Fifth Most Important _____

Third Most Important   _____   Sixth Most Important _____

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

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

Check one response: _____ _____ _____ _____ _____
                    1   2   3   4   5

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

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

Should allocate time for orientation of the nurse _____

Can't decide _____

Should not allocate time for orientation of the nurse _____

B. The nurse considers the following six issues:

1. What is my professional obligation as specified in the staff nurse job description?

2. Do I owe it to this nurse to provide guidance for her?

3. Are there other sources of orientation information available to the new nurse?

4. How can I avoid being exploited in this situation?

5. Which is greater, the right to nursing care or the right to professional orientation?

6. Which alternative would provide the greatest long range benefit to patients?

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

Most Important   _____   Fourth Most Important _____

Second Most Important   _____   Fifth Most Important   _____

Third Most Important   _____   Sixth Most Important   _____

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

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

Check one response: _____ _____ _____ _____ _____
                       1   2   3   4   5

A nurse mistakenly gave the wrong medication to an elderly woman. The nurse decided it was not serious and did not report or chart it. The woman went home the next day, but the nurse continued to wonder about untoward consequences that the woman may experience. The nurse wondered whether or not to report the incident even though it occurred yesterday.

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

Should report the medication error now _____

Can't decide _____

Should not report the medication error now _____

B. The nurse considers the following six issues:

1. Could reporting this information result in my being held accountable for negligence?

2. What nursing action would safeguard the patient's claim to fair treatment?

3. What additional, interfering assignments did I have while passing medications that day?

4. How can I meet my responsibility with integrity even though the patient has gone home?

5. Has the medication error caused unnecessary discomfort for the patient?

6. What is my duty as specified in the Code for Nurses?

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

Most Important   _____   Fourth Most Important _____

Second Most Important _____   Fifth Most Important _____

Third Most Important _____   Sixth Most Important _____

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

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

Check one response: _____ _____ _____ _____ _____
                        1   2   3   4   5

Terminally Ill Adult

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

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

Should answer the patient's questions _____

Can't decide _____

Should not answer the patient's questions _____

B. The nurse considers the following six issues:

1. How can I best follow the specifications on sharing information in the Patient's Bill of Rights?

2. Is the physician on the Unit during times when it would be possible to discuss this?

3. Are the wishes of the patient's family most important because the family is closest to the patient?

4. Would I be meeting the fair expectations of the patient and his family?

5. Could the family and the physician do anything to me for answering the patient's questions?

6. Does the patient in his own case have the right to decide about who should know the diagnosis?

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

Most Important   _____   Fourth Most Important _____

Second Most Important _____   Fifth Most Important _____

Third Most Important   _____   Sixth Most Important _____

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

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

Check one response: _____ _____ _____ _____ _____
                      1   2   3   4   5

APPENDIX E

ETHICAL BEHAVIOR INVENTORY

ETHICAL BEHAVIOR INVENTORY*

DIRECTIONS: In each of the following situations you are the nurse. Select the answer which most closely matches what you think you would do in the situation or a similar situation that is known to you. This is only an inventory to find out what nurses think they would do in hypothetical situations.

You, the nurse, are about to give a newly ordered medication. You have noticed that the ordered dosage in unusually large. You have checked your resources and found that the dosage is indeed unusually large. You called the physician who stated that the dosage ordered was to be given. What are you going to do?

  _____A. Call the nursing supervisor.
  _____B. Administer the medication.
  _____C. Call another physician for a new order.
  _____D. Inform the physician you will not give the medication

During the evening shift, a man whose wife delivered a child the day before asked whether he might stay in the room with his wife that night. She was the only patient in a semi-private room. After exploring the situation you, the nurse, believe it is important for this patient and her husband to be together. Allowing this action, however, would violate hospital policy. What are you going to do?

  _____A. Inform the husband of the hospital policy.
  _____B. Call the physician for an order to allow the husband to stay.
  _____C. Tell the nursing supervisor.
  _____D. Allow the husband to stay.

You were hired as a "float nurse." You are personally opposed to therapeutic abortions for any reason. You have not informed anyone from nursing management about your feelings. Today you are assigned to the unit where abortions are being done. What are you going to do?

  _____A. Go home sick.
  _____B. Accept the assignment.
  _____C. Tell the nursing supervisor of your objections.

You, the nurse, are about to add the last IV solution that has been ordered for a patient who had surgery two days ago. Based on your observations you question whether this patient should have additional fluids. It is 3:00 am and this surgeon has a reputation for becomming angry if called during the night. What are you going to do?

  _____A. Call the house physician.
  _____B. Call the surgeon.
  _____C. Call the nursing supervisor.
  _____D. Add the IV as ordered.

You regularly observe serious breaks in sterile technique by another registered nurse in the operating room. You are aware that serious complications could result from the carelessness of the nurse. What are you going to do?

    _____A. Confront the careless nurse.
    _____B. Inform the head nurse.
    _____C. Inform the physicians.
    _____D. Ask other staff nurses to observe.

At a staff nurse educational session, a transparency is shown with the name and extensive details about a recently discharged patient. You, the nurse, realize that the nursing care information was helpful in meeting the educational goals of the session, but are convinced that the sharing of the patient's name and personal data are inappropriate. What are you going to do?

    _____A. Tell the instructor of your convictions.
    _____B. Tell the supervisor of your convictions.
    _____C. Write your concerns on the evaluation form.
    _____D. Nothing, its really none of your concern.

An elderly lady has fallen and fractured her hip while attempting to go to the bathroom during the night. The next morning the patient's husband asked you, the nurse, questions about the fall. He is asking to know about the number and mix of staff on duty and how long it took to answer the patient's light. What are you going to do?

    _____A. Get the head nurse to answer these questions.
    _____B. Assure the husband that the hospital in not at fault.
    _____C. Tell the husband you do not know.
    _____D. Answer the questions.

During a Sunday day shift you are the only R.N. on with 24 acutely ill patients. How should you assign ancillary help (3 L.P.N.'s)?

    _____A. Divide the patients equally among the four of you.
    _____B. Divide the patients among the 3 L.P.N.'s.
    _____C. Revert to functional nursing where each person renders care
        based on competency.

You, the nurse, have noticed that the respiratory therapist is regularly coming to the unit slightly disoriented and with the odor of alcohol on his breath. Your spouse is a good friend of the respiratory therapist. You are concerned about the treatment the therapist is giving patients. What are you going to do?

    _____A. Confront the therapist with your observations.
    _____B. Tell your spouse of your observations.
    _____C. Tell the nursing supervisor of your concerns.
    _____D. Nothing, its none of your business.

A 33 year old patient asks you, the nurse, numerous questions about the experiemental chemotherapy that has been suggested by the physician. You are uncertain about the amount of information regarding detailed action of the drug, positive results noted with other patients and dangerous side effects that have been shared with the patient. What are you going to do?

      A. Refer the questions to the physician.
      B. Respond to the questions within your knowledge base.
      C. Offer assurance that all will be well.
      D. Ignore the patient's questions.

A three year old child has recently been diagnosed as having acute, terminal leukemia. Without discussing the issue with the health care team, the child's physician left town for a one week conference. The child's parents are asking you, the nurse, leading questions about the child's health. What are you going to do?

      A. Answer the parent's direct questions
      B. Refer the parents to the physician.
      C. Refer the parents to the head nurse.
      D. Ignore the parent's questions.

A month ago you noticed another nurse putting patients' medications in her purse. You have reported this to the head nurse on two different occasions. Nothing has changed and again you have seen this nurse putting patients' medications in her purse. What are you going to do?

      A. Approach the head nurse again.
      B. Approach the nurse involved.
      C. Tell the nursing supervisor.
      D. Nothing, you have done all you can.

APPENDIX F

DEMOGRAPHIC DATA INVENTORY

DEMOGRAPHIC DATA

DIRECTIONS: For each of the
following questions select the best
answer. Be sure to select ONLY ONE
answer.

1. What is your age range?
_____25 or Under
_____26-35
_____36-45
_____46-55
_____Over 55

2. How many years of nursing
experience do you have where
you have worked at least part
time?
_____Less than 2
_____2-9
_____10-19
_____20-29
_____Over 29

3. What is your basic educational
preparation for nursing?
_____Diploma in Nursing
_____Associate Degree
_____Bachelor's Degree
_____Other
If Other, please
specify _____

4. Was your basic nursing
education in an institution
with a religious affiliation?
_____No
_____Yes
If yes, what
religion?_____

5. What is your highest
educational status?
SELECT ONLY ONE
_____Diploma In Nursing
_____Associate Degree
_____Bachelor In Nursing
_____Bachelor In other
area
_____Master In Nursing
_____Master In other area
_____Doctorate in Nursing
_____Doctorate In other
area.

6. Was you basic nursing
education in a state or
territory of the United
States?
_____Yes
_____No
If no, what country?
_____

7. What is your current area
of clinical practice?
_____Medical/Surgical
_____Perinatal
_____Nursing of Children
_____Psychiatric
_____Community Health
_____Other
If other, please
specify_____
_____

8. What is your religious
affiliation?
_____Judaism
_____Catholicism
_____Protestantism
_____None
_____Other
If other, please
specify._____
_____

9. Are you a member of a
professional nursing
organization?
_____No
_____Yes
If yes, please list
all the professional
groups to which you
belong_____
_____

10. What is most important to
you in making decisions in
the presence of an ethical
dilemma?
_____Your personal values
_____Standards of Care
_____Hospital philosophy
_____Code for Nurses
_____Declaration of
Helsinki
_____Other
If other, please
specify._____

APPENDIX G

HEALTH CARE WORK POWERLESSNESS SCALE

APPENDIX H

ADDITIONAL DEMOGRAPHIC DATA

Table Eight is the frequency distribution of subjects by hospital. Hospital A is a small rural hospital. Hospital B is a small inner city hospital. Hospital C is a moderate size medical school affiliated teaching hospital. Hospital D is a moderate size major medical center hospital. Hospital E is a large religiously affiliated hospital.

Hospital	Frequency	PerCent
A	24	10.4
B	12	5.2
C	60	26.0
D	59	25.5
E	76	32.9
TOTAL	231	100.0

Table Eight: Frequency Distribution of Respondents by Hospital.

Tables Nine through Fourteen are the frequency distributions of range of years of experience, entry into practice credential, basic education in an institution with a religious affiliation, clinical area of practice, religious preference of respondents and value preference of respondents in making ethical decisions. Population data concerning these variables are not available. Thus, comparisons of the sample to the population cannot be made.

Years of Experience	Frequency	PerCent
Less than 2	23	10.0
2-9	136	58.9
10-19	47	20.3
20-29	17	7.4
30 or over	8	3.5
TOTAL	231	100.0

Table Nine: Frequency Distribution of Range of Years of Experience.

Credential	Frequency	PerCent
Diploma in Nursing	102	44.2
Associate Degree	72	31.2
Bachelor's Degree	57	24.7
TOTAL	231	100.0

Table Ten: Frequency Distribution of Respondents by Entry Into Practice Credential

Religious Education	Frequency	PerCent
No	150	64.9
Yes	81	35.1
TOTAL	231	100.0

Table Eleven: Frequency Distribution of Respondents by Basic Education in an Institution with a Religious Affiliation.

Clinical Area	Frequency	PerCent
Medical/Surgical	179	77.5
Perinatal	29	12.6
Nursing of Children	18	7.8
Psychiatric Nursing	5	2.2
TOTAL	231	100.0

Table Twelve: Frequency Distribution of Respondents by Clinical Area of Practice.

Religion	Frequency	PerCent
Judaism	2	0.9
Catholicism	122	52.8
Protestantism	89	38.5
No Preference	13	5.6
Other	5	2.2
TOTAL	231	100.0

Table Thirteen: Frequency Distribution of Respondents by Religious Preference.

Value Preference	Frequency	PerCent
Personal Values	81	35.1
Standards of Care	98	42.4
Hospital Philosophy	23	10.0
ANA Code for Nurses	16	6.9
Other	13	5.6
TOTAL	231	100.0

Table Fourteen: Frequency Distribution of Respondents by Value Preference in Ethical Decision Making.

Table Fifteen is the frequency distribution of the age range of respondents. In this sample 24.7 percent were 25 or under. The ANA (1983) reports that 7.7 percent of all registered nurses (1980 data) in the United States are 25 or under. This higher percentage of 25 or under nurses may be accounted for because the data collection sites were hospitals. New graduate nurses are encouraged to work on a medical surgical unit of a hospital for at least one year before seeking employment in other agencies.

In this sample 41.1 percent of the nurses were 26-35. The ANA (1983) reports that 32.8 percent of all registered nurses are 26-35. This difference may represent that these nurses have not yet achieved the seniority to be promoted into positions of authority.

In this sample 21.6 percent were 36-45. In the ANA estimate (1983 publication using 1980 data) 23.2 percent of the population of nurses were 36-45. There appears to be no difference between the sample and the population on age range in the 36-45 year old age range.

In this sample 10.8 percent were aged 46-55 and 1.7 percent over 55. The ANA population estimates are 17.2 percent 46-55 and 19 percent over 55. The significant differences may be accounted for because only staff registered nurses were asked to be subjects in this study. These older nurses may have achieved the seniority to be promoted to more powerful positions in the hospital

organization.

Age Range	Frequency	PerCent
25 or under	57	24.7
26-35	95	41.1
36-45	50	21.6
46-55	25	10.8
Over 55	4	1.7
Total	231	100.0

Table Fifteen: Frequency distribution of Age
Range of Respondents.

Table Sixteen is the frequency distribution of current
educational preparation for practice of the respondents. The
raw data do not reflect that several (9) nurses reporting
diploma as basic educational preparation for practice now
report holding associate degrees. This accounts for the
discrepancy between Table Sixteen and Table Ten on this
variable. According to the ANA (1983, using 1980 data) 71.4
percent of the population of registered nurses are prepared
at the sub-baccalaureate level where in this sample 64.1
percent are prepared at the sub-baccalaureate level. The ANA
population estimates are that 23.4 percent of nurses are
prepared with a baccalaureate degree, where in this sample 35
percent are prepared at the baccalaureate level. The ANA
also estimates that 5.3 percent of the population of nurses
are prepared at the masters level, where in this sample 0.8
percent are prepared at the masters level. These significant

differences can be accounted for by two factors. First, the data from which the population is estimated was compiled in 1980. These data do not reflect the changed attitudes in favor of baccalaureate education in the last five years. Further, it does not reflect the closing of diploma programs in nursing. In Michigan 18 diploma programs in nursing have closed since 1980, either not replaced or replaced with nursing programs in institutions of higher learning. Secondly, since only staff nurses were approached, it is reasonable to conclude that the numbers of masters prepared nurses would be low. Nurses with masters preparation are generally in roles in hospitals which would not be included in this sample or in schools and colleges of nursing.

Practice Credential	Frequency	PerCent
Diploma in Nursing	75	32.5
Associate Degree	73	31.6
Bachelor Nursing	71	30.7
Bachelor Other Area	10	4.3
Master Nursing	1	0.4
Master Other Area	1	0.4
TOTAL	231	100.0

Table Sixteen: Frequency Distribution of Current Educational Preparation for Practice of Respondents.

Table Seventeen is the frequency distribution of

respondents by ANA membership. The ANA reports that 9.6 percent of the population of nurses hold membership in that organization as of 1980. In the sample, 11.3 percent of respondents hold membership in the ANA. This may be explained because two of the hospitals used for data collection were, until recently, organized for collective bargaining purposes under the ANA. The nurses in those institutions may have continued membership out of habit or because the value of membership was seen. Further, since the population data were compiled in 1980, and since there are more degreed respondents in this sample as evidenced in Table Sixteen, there may be a difference between diploma and degree membership in the ANA which may account for this difference between the population and sample.

ANA Member	Frequency	PerCent
Yes	26	11.3
No	205	88.7
TOTAL	231	100.0

Table Seventeen: Frequency Distribution of Respondents by Membership in the American Nurses Association.

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ABSTRACT

ETHICAL DECISION MAKING BY HOSPITAL NURSES

by

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The hospital nurse is required to make decisions that affect the lives of patients. The American Nurses Association Code for Nurses ought to be the framework used by nurses in making those ethical decisions. The Code is not the primary basis for ethical decision making as has been shown in this and previous research.

In this research the role of hospital employer, personal and professional values of staff nurses has been examined for their influence on the ethical decisions made by nurses. The nurses completed the Health Care Work Powerlessness Scale, and the Nursing Dilemmas Test and Ethical Behavior Inventory. The test scores were analyzed using the Pearson Product-Moment Correlation Coefficient (r). Demographic characteristics of the nurses, such as age, religion, religious education, basic and current educational preparation for practice and ANA membership were also obtained. Test scores were recoded into categorical data so that the data could be analyzed using Chi Square.

In a convenience sample of 231 registered nurses practicing as staff nurses in hospital in-patient settings

significant negative relationship was idenfied between the
Health Care Work Powerlessness Score and the Code Congruency
score on the Ethical Behavior Inventory (R=-0.1363, p=.019).
An Additional significant relationship was identified between
educational preparation for practice outside the United
States and Code Congruency scores. It was found that as
powerlessness increases Code congruency descreases and that
Code congruency was lower in nurses educated outside the
United States. (χ^2=20.50102, df=2, p<.05).

Recommendations are made for further research.

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