NURSES' VALUES AND PERCEPTIONS OF ETHICAL RESPONSIBILITY

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"The struggle itself toward the heights is enough to fill a man's heart. One must imagine Sisyphus happy."

(Camus, The Myth of Sisyphus, p. 91)

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CHAPTER 1

INTRODUCTION

Expansion of knowledge, such as professional nurses witness in response to the achievements of science and technology, inherently involves the consideration of values and decisions related to the nursing process. As knowledge increases, so does the availability of choices; these choices are reflected in ethical behavior.

Nurses in all areas of practice are beginning to think critically about values, principles of ethics, ethical reasoning, and ethical behavior (Bandman, 1979; Crisham, 1981; Curtin, 1978, 1979; Wilson, 1974). Advances in scientific knowledge, technological achievement, rapid industrialization, and the resultant complexity of health care systems have evolved unique societal problems. As the values, beliefs, and practices of individuals are altered, societal norms change. With these alterations, new approaches to life, liberty, and personal pursuits are established.

Currently the concept of humanism has been advocated as the approach considered most congruent to the rights of the individual in regard to health care. Public

response to this approach is reflected in such media-addressed phrases as "quality of life," "heroic measures," "right to die," "right to life," and the "rights of individuals to receive humane and enlightened health care." Within this humanistic approach, however, the rights of individuals are often compromised by the mastery of scientific endeavors. This compromise leads to issues of conflict, choice, and conscience. Collectively, these issues define the discipline of bioethics and represent crucial challenges to nurses and physicians who assume responsibility for the health care needs of individuals.

Professional nurses, whether in situations of authority or advocacy, are required to make decisions about the health care needs of clients. Responsible decision-making involves consideration of the value system and ethical orientation which helps to define the person of the nurse as well as that of the client. In situations involving conflict the values, beliefs, attitudes, and expectations of nurses and clients converge, often precipitating further conflict in the nurse. Consequently, the specific question addressed in this research was: Is there a relationship between selected values of nurses and the nurses' perception of ethical responsibility in nursing practice?

Statement of Problem

The problem of this research study was to determine the relationship between selected values of nurses and the nurses' perception of ethical responsibility in nursing practice.

Justification of Problem

Although the concepts of values and ethics have been applied throughout the philosophical and theological domains, few empirical studies have been employed to ascertain their relevance to the nursing profession. Experiential evidence suggests that the ethical concerns of practicing nurses occur daily in their interactions with clients. Nursing educational preparation in the consideration of the concepts of value orientation and ethical reasoning has been scanty or anecdotal. Practicing nurses, therefore, are not adequately prepared for effective problem-solving approaches when confronted with clinical situations involving conflict or dilemma. The variety of situations in which a nurse attempts to resolve these conflicts is matched by a variety of decision-making abilities. Shirk (1965) maintained that

> since nursing decisions are concerned with human life and directly affect the welfare of all human beings, they ought to be measured by ethical or moral standards. (p. 23)

The transactional nature of the relationship between the client and nurse poses a unique fusion of the personal belief systems to which each ascribes. Identification and understanding of these belief systems is a prerequisite for the accurate and humanistic assessment of the clients' health care needs. This notion was supported by Wilson (1974) who held that the unique contribution of the nurse to this assessment requires

> an opportunity to confront and develop awareness of her own value system; an ability to separate herself, her values, and her experiences from those of others; and, a means of accepting, allowing, and integrating the different values and behaviors of others within herself. (p. 7)

This empirical investigation of the relationship of the nurse's value system and perceived responsibility in an ethical dilemma was considered to be vitally significant to the growth and maturation of the nursing profession as well as to the client's well-being.

Theoretical Framework

This study was based on two theoretical formulations: (a) personality theory and (b) cognitive-developmental theory of moral reasoning.

Personality Theory

The complex dynamics of personality are given a humanistic orientation in a theory formulated by Allport (1955, 1959, 1961). This theory advocated the qualitative study of the individual and the inherent uniqueness of selfhood. The major premise of this theory stated that in spite of the complexity of the individual, the main trends in his nature display an underlying congruence or unity (Hall & Lindzey, 1970). Allport (1961) defined personality as "the dynamic organization within the individual of those psychophysical systems that determine his characteristic behavior and thought" (p. 9). According to Allport (1955), personality includes

> habits and skills, frames of reference, matters of fact and cultural values, and all the regions of our life that we regard as peculiarly ours. (p. 40)

Personality is viewed as a transitive process rather than a finished product. While personality possesses stable features, it is at the same time continually undergoing change. The theorist stated that "it is this change, this becoming, this individuation" (Allport, 1955, p. 19) that characterizes the psychology of the individual. An analysis of this statement serves to categorize some of the main constructs of Allport's theory.

Change. Allport's theory proposed important changes of personality between infancy and childhood. The newborn infant is considered to be without personality; the infant is a creature of heredity, primitive drive, and reflex existence. He has not yet developed those distinctive attributes which will appear later as a result of interactions with his environment. This state is altered very early and gradually. Allport concluded that by the end of the first year of life, the infant begins to show distinctive qualities which presumably represent enduring personality attributes. The transition of the infant into a young adult occurs along multiple lines and involves several processes of self-awareness. As an outcome of these growth and maturational experiences, the individual constantly experiences change.

Allport (cited in Hall & Lindzey, 1970) viewed the mature individual as a "person whose major determinants of behavior are a set of organized and congruent traits" (pp. 275-276). These traits or personal dispositions cannot necessarily be observed directly but have to be inferred from behavior. The adult personality is viewed by Allport (1955) as a hierarchy of interests, including the loves, hates, loyalties, and values which structure the individual's place in a complexly ordered society.

Becoming. Becoming is the process of incorporating earlier stages into later ones and accounts for the transformation into maturity. According to the theory, the necessary outlines on a psychology of becoming can be discovered by looking within oneself. Allport (1955) stated that "it is knowledge of our own uniqueness that supplies the first, and probably the best, hints for acquiring orderly knowledge of others" (p. 23). By reflecting on factors that seem vital in one's own experience of becoming, the identification of important issues results. Some of these issues include: the nature of inborn dispositions; the impressions of culture and environment; the conscience; the evolving style of expression; the experiences of choice and freedom; the management of conflicts and anxieties; and finally, the formation of maturer values, interests, and aims.

Individuation. The humanistic perspective of adult personality as viewed by Allport (1955, 1959, 1961) is consistently reflected in the emphasis placed on the uniqueness and individuality of each person. Allport (cited in Hall & Lindzey, 1970) offered that "it is only by knowing the person as a person that we can predict what he will do in a given situation" (p. 278). This emphasis places important significance on traits or

personal dispositions as the primary determinants of behavior and thought. Individuation is defined as "the formation of an individual style of life that is self-aware, self-critical, and self-enhancing" (Allport, 1955, p. 28). In contrast to other personality theorists who focused their observations on neurotic or negative characteristics of behavior, Allport was committed to represent the positive aspects of self. Allport (1955) stated

> all psychological functions commonly ascribed to a self or ego must be admitted as data in the scientific study of personality. These functions are not, however, coextensive with personality as a whole. They are rather the special aspects of personality that have to do with warmth, with unity, with a sense of personal importance. (p. 55)

These functions of self are called the "proprium" and include all aspects of personality that make for inward unity. The selfhood or proprium includes the following functions: development of a sense of one's body, self-identity, ego enhancement, ego extension, rational activity, self-image, propriate striving, and knowing (Allport, 1955). Allport summarized that the proprium is not a thing separable from the person as a whole; rather it is a term which describes the fusion of all the functions of an emerging self. This fusion accounts for the individuality and uniqueness of each person.

Values. Allport's (1955) theory elucidates the importance of values as decisive factors in becoming. Values, defined philosophically, are the termini of one's intentions. Values represent inner convictions of what is right or wrong, good or bad, desired or undesired. They are the filters through which one strains the impressions of life and of living. The psychologically healthy adult, according to Allport, develops under the influence of a value schemata whose fulfillment he regards as desirable even though what one values may never be completely attained. These aims or intentions, however unattainable they might be, exert a dynamic effect upon daily conduct. In this way, values become philosophical creeds and determine the significance and meaning of relations with others. The individual selects his perceptions, consults his conscience, inhibits irrelevant or contradictory lines of conduct, and rejects activities discordant with his value commitments. The theorist further stipulated that as active schemata for conduct is developed, a dynamic influence upon specific choices for activity is exerted. Thus, one refers decisions to one's schemata of values.

Allport (1955) reasoned that even the best integrated of personalities do not always act consistently within their value organization. He cited irresistible forces, violations of conscience, threads of infantilism, and alien role behavior as factors which influence daily lives. Allport concluded, however, that in spite of such conflicts, individuals develop a personal living style which proceeds from the proprium (self) outward. This personal stamp of individuality reveals one's values.

Allport's theoretical formulations on the concept of values directly intertwined with that of the work of Spranger (cited in Allport, 1955). Spranger viewed that the major characteristic of any personality is the individual's philosophy of life, his value system. Spranger classified six types of personality: the theoretical, economic, aesthetic, social, political, and religious. His work defended the view that personalities are best known through a study of values or evaluative attitudes. According to Spranger's view, a person can best be understood by his predominant interests and intentions, rather than by his achievements (Allport, Vernon, & Lindzey, 1970). Spranger's view of personality did not imply that a given individual

belongs exclusively to one or another of these value types. Spranger (cited in Allport et al., 1970) confirmed that his depictions of value types were referenced toward the "ideal."

The six types of personality described by Spranger were classified by Allport et al. into six value types utilizing the same terms of Spranger. These six value types were described as follows:

1. The theoretical--the dominant interest of this type is a scientific or philosophical discovery of truth. In this pursuit, one focuses on cognitive attitudes, critical and rational thinking, and intellectual or scholarly endeavors (Allport et al., 1970).

2. The economic--the dominant interest of this type is utility and practicality. In this pursuit, one focuses on the acquisition of material goods, wealth, and tangible prosperity for the benefit of self (Allport et al., 1970).

3. The aesthetic--the dominant interest of this type is form and harmony; the chief interest is the artistic episodes of life. In this pursuit, one focuses on the symmetry, fitness, or creativity of each experience in life. The interest is on

individualism and self-sufficiency rather than on the social welfare of other persons (Allport et al., 1970).

4. The social--the dominant interest of this type is on the altruistic or philanthropic aspect of love. In this pursuit, one focuses on other persons as ends; therefore, one who is social is considered to be kind, sympathetic, and unselfish. This type refers to love as the only suitable form of human relationship (Allport et al., 1970).

5. The political--the dominant interest of this type is power, authority, and leadership. In this pursuit, competition and struggle are ubiquitous concerns. The ultimate motive is for personal power, influence, and renown (Allport et al., 1970).

6. The religious--the dominant interest of this type is unity; religious experiences are considered the affirmation of life. In this pursuit, one focuses on the relationship of self to the universe for the goal of finding spiritual meaning and significance (Allport et al., 1970).

Allport's (1955) theory is summarized in these statements: The most comprehensive units in personality are broad intentional dispositions; these dispositions

include traits and values which are unique for each person. These characteristics serve to attract, guide, or inhibit the behavior, thoughts, and choices of an individual. The theorist advocated that knowledge about the interests and motivations of individuals is vital so that conflicts between and among individuals can be better managed (Allport, 1959). Allport (1955) contended that

> While recent empirical investigations have abundantly proved that personal values do in fact steer and select perceptions, judgments, and adjustments, there is still inadequate recognition of the theoretical significance of this discovery. (p. 89)

Cognitive-Developmental Theory of Moral Reasoning

Empirical studies by Kohlberg (1969, 1972, 1973a, 1973b) elaborated on the cognitive-developmental approaches to education formulated by Dewey (1909) and Piaget (1932). According to Kohlberg, an individual moves through stages of reasoning as one integrates values and moral principles into one's active thinking about moral situations. These stages are structures of the level of moral reasoning (Kohlberg, 1972). Kohlberg delineated 10 universal issues used by an individual

as the basis of moral reasoning in situations of conflict. These issues included the following: (a) punishment, (b) property, (c) roles and concerns of affection, (d) roles and concerns of authority, (e) law, (f) life, (g) liberty, (h) distributive justice, (i) truth, and (j) sex. According to the theorist, a moral choice involved the necessity of choosing between two or more of these issues as they conflicted in concrete situations of choice (Kohlberg, 1973a). Kohlberg proposed that it is the underlying reasoning of an individual which is assessed rather than the actual choice made by the individual. This reasoning indicates the stage of moral development (Kohlberg, 1972).

Kohlberg's theory identified three levels of moral reasoning; these levels are preconventional, conventional, and postconventional. At the preconventional level the individual is responsive to cultural rules and labels of good and bad, right or wrong. One interprets these labels either in terms of the physical power of those who make the rules and labels or of the hedonistic consequences of action (punishment, reward, exchange of favors). At the conventional level of moral

reasoning, maintaining the expectations of the individual's family, group, or nation is perceived as valuable, regardless of immediate and obvious consequences. The attitude is not one only of conformity to personal expectations and social order, but of loyalty and active identification to it. At the postconventional level, moral reasoning is an autonomous process of defining moral values and principles that have validity and application apart from the influence of authority and group identification (Kohlberg, 1973b).

Within these levels, six stages or orientations of moral reasoning were identified:

Preconventional level--Stage 1. The punishment-and-obedience orientation. The physical consequences of an action determine its goodness or badness regardless of the human meaning or value ascribed to the consequences. The notions of avoiding punishment and of unquestioning deference to power are valued in their own right, not out of respect for an underlying moral order.

Preconventional level--Stage 2. The hedonistic or instrumental-relativist orientation. In this stage

the right action consists of that which instrumentally satisfies one's own needs and occasionally the needs of others. The notions of fairness, of reciprocity, and of equal sharing are present, but they are always interpreted in a physical pragmatic way. Reciprocity is a matter of "you scratch my back and I'll scratch yours," rather than of loyalty, gratitude, or justice.

Conventional level--Stage 3. The interpersonal concordance or "good boy--nice girl" orientation. In this stage, one earns approval by being "nice" to the members of one's immediate group. Behavior is frequently judged by intention; good behavior is that which pleases or helps others and is approved by them.

Conventional level--Stage 4. The "law and order" orientation. In this stage the orientation is toward authority, fixed rules, and the maintenance of the social order. The right behavior is viewed as consisting of doing one's duty, showing respect for authority, and maintaining the given social order for its own sake.

Postconventional level--Stage 5. The social-contract, legalistic orientation. In this stage, the

right action tends to be defined in terms of general individual rights, and standards which are critically examined and sanctioned by society. Aside from what is constitutionally and democratically agreed upon, the right is a matter of personal values and opinions. The result is an emphasis upon the legal point of view but includes the notion of changing the law based on rational considerations of its social utility. Outside the legal realm, free agreement and contract is the binding element of obligation. This stage of thinking is the "official" morality of the American government and constitution.

Postconventional level--Stage 6. The universal-ethical-principle orientation. In this stage, the right action is determined by a decision of one's conscience in accord with self-chosen ethical principles appealing to logical comprehensiveness, universality, and consistency. These principles are abstract and ethically based rather than concrete moral rules. Thinking at this stage involves universal principles of justice, of the reciprocity and equality of human rights, and of respect for the dignity of human beings as individual persons.

Kohlberg's (1973b) stages defined ways of thinking about moral matters or about matters involving choice. Kohlberg determined that each stage is defined by the values or issues that enter into moral decisions. In Kohlberg's view, Stages 1 and 2, which are typical for young children and delinquents, are classified as "premoral" since decisions are made largely on the basis of self-interest and material considerations. The group oriented Stages 3 and 4 are classified as conventional and describe the level of thinking at which most adults operate. At the principled or post-conventional level, Kohlberg assessed that approximately 20% of the adult population operated at Stage 5 with perhaps 5% to 10% arriving at Stage 6.

Stage orientation appears to be a consistent phenomenon. The theorist maintained that most people are quite consistent in their use of a single type of thinking. This consistency appears to hold constant regardless of the content of the conflict or dilemma presented. Kohlberg further determined that approximately 50% of an individual's statements about moral situations correspond to a dominant stage. The remaining statements are generally divided into the stages

immediately above and below the dominant stage (Kohlberg, 1972).

In summarizing the cognitive-developmental levels of moral reasoning, Kohlberg (1972) claimed that "morality represents a set of rational principles of judgment and decision for every culture, the principles of human welfare, and justice" (p. 14). Moral judgment is considered to be primarily a function of rational operations. Kohlberg acknowledged that affective factors such as the ability to empathize and to experience guilt do enter into an individual's perception of choice. However, Kohlberg viewed that moral situations are defined cognitively rather than affectively by the judging individual. Moral development is, therefore, a result of an "increasing ability to perceive social reality or to organize and integrate social experience" (Kohlberg, 1972, p. 15).

Theoretical generalizations pertinent to an individual's system of value and cognitive-developmental level of moral reasoning have been presented. Based on these theories, one can surmise that since decisions are referred to one's schemata of values, then decisions involving moral or logical reasoning will be representative of the relative importance an individual ascribes

to selected value referents. Knowledge of one's values, therefore, may be predictive of one's moral or ethical perception. This investigation sought to investigate the relationships between selected values of nurses and their perception of ethical responsibility in nursing practice.

Assumptions

Assumptions which undergrid the study were:

1. Values underlie all behavior.

2. The terms "ethical" and "moral" can be used interchangeably.

3. A principled level of moral reasoning is desirable for professional practice by oncology nurses. The principled level of moral reasoning is reflected in Kohlberg's (1969) Stage 5 and Stage 6 thinking.

Definition of Terms

The following terms were considered significant to this investigation. When necessary both theoretical and operational definitions are given.

1. Value--"the termini of our intentions" (Allport, 1955, p. 90). "A belief upon which man acts by preference" (Allport, 1961, p. 464).

2. Selected values--the actual score on the Allport-Vernon-Lindzey Study of Values instrument for each of the following value types: theoretical, economic, aesthetic, social, political, and religious.

3. Oncology nurse--an individual meeting the study criteria who is employed in the practice of rendering nursing care to patients with oncological problems.

4. Nursing practice--the general milieu of the nursing profession in which registered professional nurses render nursing care to specific clients.

5. Perceived ethical responsibility--the composite score of nursing principled thinking, practical considerations, and familiarities with ethical dilemmas as measured by the Nursing Dilemma Test (Crisham, 1978).

(a) nursing principled thinking--the actual score measuring the importance given to principled considerations in making a nursing moral decision as measured by the Nursing Principled (NP) thinking index on the Nursing Dilemma Test (Crisham, 1978).

(b) practical considerations--the actual score measuring the relative importance given to practical considerations in making a nursing moral decision as

measured by the Practical Considerations (PC) index on the Nursing Dilemma Test (Crisham, 1978).

(c) familiarity with ethical dilemmas--the actual score measuring real life nursing dilemmas as measured by the Familiarity with ethical dilemmas (F) scale on the Nursing Dilemma Test (Crisham, 1978).

Hypotheses

The hypotheses tested in this study were:

1. There are no significant relationships between the composite score measuring perceived ethical responsibility as measured by the nursing principled thinking score, the practical considerations score and the familiarity with ethical dilemmas score on the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

2. There are no significant relationships between the single score measuring nursing principled thinking as measured by the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

3. There are no significant relationships between the single score measuring practical considerations as measured by the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

4. There are no significant relationships between the single score measuring familiarity with ethical dilemmas as measured by the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

Limitations

Relevant generalizability was limited by the following factors:

1. Perceptions of ethical responsibility as determined by the Nursing Dilemma Test may not be congruent with perceptions of ethical responsibility in actual clinical settings.

2. Each person has unique patterns of socialization, cognitive functioning, professional experiences, and situational stressors which will not be controlled

and which may have an unknown effect on the data obtained.

3. The Nursing Dilemma Test is a newly constructed instrument and has not been used extensively.

4. There was no control over the setting of this study.

Summary

Values are central beliefs or motivational forces within nurses. Knowledge of what nurses value is essential to an understanding of the ethical decision system within which the nurse operates. Chapter 1 has provided an introduction to the study of nurses' values and their ethical responsibility in practice. The problem was identified and its justification to the nursing field was developed. The problem was supported within two theoretical frameworks. Concepts relevant to the inquiry were extracted from the theories and presented as null hypotheses which attempted to concretely determine the theoretical abstractions. The necessary terms were given theoretical and operational definitions. Finally, limitations to the study's generalizability were supplied.

CHAPTER 2

REVIEW OF LITERATURE

The foundational ideas of this study focused on personal value systems of nurses and their interrelation to elements which comprise ethical responsibility in nursing practice dilemmas. This relationship has been neglected in research efforts and accounts for the apparent lack of empirical studies linking these concepts.

The reviewed literature considered supportive to this present investigation is organized into five sections. Section one discusses value systems in nursing. Section two presents selected nursing research on the study of values. Section three discusses dimensions of ethical responsibility in nursing practice. Section four provides an overview of Kohlberian moral developmental research. Section five presents selected research on moral development in nurses.

Value Systems in Nursing

Values comprise the diverse universe of all human behavior. Value theory holds that there is a social dimension to both values and behavior, but that each is viewed

as an entity separate from the other. The difference between these two entities is distinguished by Williams (1960) who determined four qualities of values:

1. Values have a conceptual element which is more profound than mere sensations, emotions, or needs. In this sense, values can be thought of as abstractions drawn from one's experiences.

2. Values are affectively charged, or involve some understanding which has an emotional aspect. Emotion may not actually be expressed, but it is always a potential.

3. Values are not concrete goals of action, but they do relate to goals in that they serve as criteria for their selection. One strives for those things one values.

4. Values are important matters and not the least trivial to the individual. This can be observed in the fact that values relate to choices, which precede action.

An individual's value system is one of the characteristics by which he is known or described by others and by which he describes himself. Values are developed and incorporated into one's life through the process of socialization. According to Rokeach (1973) the antecedents of human values can be traced to culture, to society and its

institutions, and to personality. The consequences of human values will be manifested in virtually all phenomena that the social scientist might consider worth investigating. Socialization, according to Fromer (1981), is viewed as one or a combination of any of the following.

> 1. The process by which a person learns the culture and mores of a group so he can function in it.
> 2. The narrowing of an individual's inborn behavioral potentials to a certain specified range.
> 3. The learning of social roles and attitudes of a particular group. (p. 7)

Fromer (1981) further declared that personal

> values imply a certain steadiness of character and are an anchor in a world that changes rapidly and is often violent and confusing. They can be a shelter, a haven of personal behavior when one is confused and perplexed by the values of others. (p. 15)

Maslow (1959), a pioneer in the field of humanistic psychology, contributed a unique theory of human motivation which attempted to bridge the world of science with the world of aesthetics. The theorist believed that the "good values"--serenity, knowledge, courage, honesty, unselfishness, and goodness--are the ultimate possessions of a psychologically healthy person.

Professional values are a reflection and expansion of personal values (Fromer, 1981). The socialization of

professionals is a major determinant of the individual's perception of roles, responsibilities, and relationships with colleagues and with clients. The profession of nursing possesses its own value system which is organized around inherent philosophical and psychological beliefs about man. Based on the current trend toward humanism within the society served by nursing, the profession of nursing seems to have adopted a humanistic value system (Gadow, 1980). Watson (1979) asserted that this humanistic value system must be combined with the scientific knowledge base that provides direction for nursing practice. In the development of the theory of caring as the essential ingredient of the nurse-client relationship, Watson proposed that this integration of philosophy and science requires that nursing develop a humanistic-altruistic orientation. Watson supported the notion of maturity developed by Allport (1961) and held that the maturing individual begins a process of associating and internalizing the human meaning of values; this process is related to the achievement of social purposes and intentional behavior.

Gadow (1980) affirmed that there is "no element of nursing that is without humanistic issues" (p. xviii). Acknowledging the pluralistic values of a scientifically

advanced society, Gadow delineated three approaches for the development of humanistic value system in nursing. The first is a historical approach which focuses on the origin and evolution of present values in nursing; especially relevant to this inquiry is the critical examination of health care systems and health care professionals. The second approach is an aesthetic one, focusing on the unique, nonquantifiable dimensions of human experience. The aesthetic approach addresses the subjective and expressly individual aspects of the experience of illness. Finally, the philosophical approach addresses the issue of the ethical permissability of certain health care practices. Additionally, this approach investigates questions dealing with the fundamental nature of human relating. Gadow (1980) based these approaches on the belief that the principal elements of the nurse-client relationship are the individuals themselves; and thus, it is "the human, nontechnical value dimensions [which] are by definition the essential aspect of the practice of nursing" (p. xviii).

Value systems, however, are much more than simplistic statements of what an individual treasures and regards as principles of life. Value systems provide the framework

upon which daily decisions and actions are based. The value one ascribes to matters of life, health, and the welfare of others determines how one perceives and responds in a relationship. In this way personal value systems both affect and are affected by the values to which a profession ascribes (Fenner, 1980).

Selected Nursing Research on the Study of Values

A review of the literature suggested that the investigation of values of nurses is mostly limited to research involving nursing students. Six studies (Brand, 1967; Dustan, 1964; Gortner, 1968; May & Ilardi, 1970; Redman, 1966; Smith, 1968) were reported in Nursing Research. These studies contained hypotheses which are similar and which in general fall into two categories: (a) comparison of the values of nursing students with the values of students in other college-age populations, and (b) changes that occur in the values and characteristics of nursing students during their educational experience. In these studies the Allport-Vernon-Lindzey Study of Values (Allport et al., 1970) instrument was employed to study theoretical, economic, aesthetic, social, political, and religious values of the various populations. All six

studies revealed that female student nurses scored highest on religious values and lowest on economic values. These findings represented a consistent value profile for the general population of nursing students during the years 1964-1970.

Different results were obtained by Garvin (1976) who investigated the difference in values between male and female nursing students. The Allport-Vernon-Lindzey Study of Values was administered to a sample of 841 female and 34 male student nurses at the Ohio State University School of Nursing. Data were treated with one-way analysis of variance and student's t-test for comparison. Results determined that female nursing students in this sample scored highest on the social values rather than the religious values; lowest female scores were on economic values and political values. Male nurses scored higher than females on theoretical values ($p < .01$) and significantly lower than females on the religious values ($p < .001$).

These results were consistent with a similar study conducted by O'Neill (1973). A sample of 465 baccalaureate students was derived from three nursing programs in the Midwest. The Allport-Vernon-Lindzey Study of Values was administered to female baccalaureate nursing students and

to general college females. Analysis of variance was used to assess the differences between mean scores of each group on the six values measured by the Study of Values. Findings supported the earlier study with high social value scores and low economic value and political value scores in nurses. Additionally, an interesting difference between nursing students and students in other curricular fields was noted on the theoretical value score. The theoretical value score as determined by Allport et al. (1970) is associated with higher intellectual characteristics and scholarship. In the O'Neill study, baccalaureate nursing students reflected a significantly higher average score on the theoretical value than did the students in general college fields ($p < .01$).

Based on Allport's (1955, 1961) theoretical notion that values are best determined by knowledge of personality characteristics, Smith (1968) conducted a factor analysis of personality structure in beginning nursing students. A sample of 546 freshmen nursing students from 10 hospital based schools of nursing in Baltimore was administered the Allport-Vernon-Lindzey Study of Values and the Edwards Personal Preference Study (EPPS). The 21 variables produced by combining the six values of the Study of Values

and the 15 needs measured by the EPPS were reduced to 7 factors. Each factor was used to describe a dimension of personality thought to be a motivational factor resulting in the selection of nursing as a career. The seven factors were described as follows: tender-hearted, strong-willed, religious-mystic, humble-religious, dependent-achiever, intellectual-achiever, and abasement-independent. The investigator, acknowledging that these results cannot be generalized to a population, reported that some of these factors appeared to include characteristics that may facilitate the nursing role, and some may lead to success more than others. This study suggests that motivation to nursing is no simple, single dimension, but rather a complex process involving many needs and values (Smith, 1968).

A study comparing the values of clinical nursing instructors with a group of intermediate professional nursing students and liberal arts students was conducted by Redman (1966) at the University of Washington. Data obtained from the Allport-Vernon-Lindzey Study of Values determined that clinical nursing instructors scored highest on theoretical values and aesthetic values; their students scored highest on social values. Differences were also observed in the theoretical value scores by instructors in different

nursing programs; instructors in the degree program placed higher significance on the theoretical value than their counterparts in the diploma schools. This difference was not observed in the student population.

Dimensions of Ethical Responsibility in Nursing Practice

As nurses expand their scope of practice in response to the accelerated development of science and technology, they are confronted with ethical, legal, and philosophical considerations. Attempts to regulate the profession of nursing in accordance with the demands of a changing society are observed in the development of standards of practice and nurse's code of behavior. These directives attempt to define the parameters of professional responsibility and accountability, and aim to provide a framework for professional judgments regarding nursing care. Although these directives may assist in regulatory functions of the profession, their utility is hampered by the fact that they provide only peripheral guidelines for responsibility to the individual nurse-client situation (Bush & Alford, in press).

The concept of responsibility defies precise definition. Neff (1973) determined that responsibility refers

to the voluntary assumption of a duty or obligation. Peplau (1971) stated that responsibility expresses an expectation or a charge to do something for which one is answerable or accountable.

Professional responsibility is viewed by Fromer (1981) as the provision or enhancement of self-reflection, ethical thought, and personal growth. Fromer (1981) further stipulated that

> whether one is accountable to the client, the institution, or society at large, one is always, definitely, and finally accountable to oneself, and one must function in a way that reflects and harmonizes with one's beliefs. (p. 11)

In describing the nurse-client relationship as a relationship of shared humanity, needs, and rights, Curtin (1979) determined that the purpose of nursing should be a moral or ethical one. Proposing the patient advocate model as the philosophical foundation and ideal of nursing, Curtin asserted that it is the wise and humane application of knowledge and skill which is the nurses' professional responsibility. This perspective was supported by Levine (1977) who regarded the quality of moral commitment as an essential measure of the nurses' excellence. This commitment implies in the nurse a willingness to assume ethical responsibility in all dimensions of practice.

Issues confronting the nurse practitioner which impinge on this commitment include decisions regarding the prolongation, quality, and termination of life. More recent sophistications in medicine and science present issues involving the genetic engineering of life and the transplantation of vital organs to sustain life. These issues reflect ethical concepts of justice, truth, compassion, and duty (Davis & Aroskar, 1978). Levine (1977) determined that "there is little in nursing education that prepares the nurse to be a perceptive witness to the moral issues that arise in practice" (p. 846).

Sigman (1979) stated that every ethical problem an individual encounters includes two components. First, the problem or dilemma requires that a personal choice be made. This choice is the outcome of one's thinking about what should or ought to be done. Secondly, the ethical dilemma requires that the responsible individual render a judgment. This judgment reflects the action agreed upon and is usually expressed as an evaluative statement of the most desirable outcome.

Ethical decisions about patient care require competent assessment by the nurse. The choice of nursing interventions specific to a particular patient situation

is usually based upon the nurse's scientific or theoretical knowledge, previous clinical experience, and personal competence in decision-making (Mahon & Fowler, 1979). Dickoff and James (1970), however, have asserted that the nurse's "increased capacity to cultivate conceptual awareness of beliefs, values, and their justification tends to increase competence" (p. 426) in nursing assessments.

When observed within the framework of humanistic practice, Bandman (1979) affirmed that

> Each nursing practitioner, whether motivated by ethical principles of rights, love, duty, or utility is fundamentally supporting the most basic human values of all, which are the right to autonomy and self-determination. (p. 62)

This motivation is a product of many variables, one of which is the individual's cognitive level of logical reasoning. Several researchers (Crisham, 1981; Ketefian, 1981; Mahon & Fowler, 1979; Murphy, 1976) have determined that logical reasoning about ethical dilemmas in nursing is reflected in the nurse's stage of moral judgment. The level of reasoning involved in being an effective moral agent or advocate of clients appears to be a principled or postconventional level; this level reflects Kohlberg's (1969, 1973a, 1973b) Stage 5 and Stage 6 thinking (Aroskar, 1977; Crisham, 1981; Ketefian, 1981;

Levine, 1977; Mahon & Fowler, 1979). Murphy (1976) contended that for nurses to act independently in a complex milieu and to act as professionals who are responsible and accountable for nursing judgments, nurses must have attained a postconventional level of maturity.

Schoenrock (1978) cautioned that when responsible, independent nurses are interfaced with bureaucratic norms requiring adherence to rules, regulations, authority, and instructional protocol, problems of moral conflict may occur. Ketefian (1981) affirmed that nurses functioning as agents of change in this climate must be operating at a principled level of moral reasoning in order to handle conflicts of duty or of competing values. Optimal functioning within a humanistic-altruistic orientation, therefore, requires the nurse's perception of ethical responsibility to be

> a factor of the value system which guides the behavior of the nurse, the most basic premise being that the value system of the patient will be recognized, defended, and even cherished. (Levine, 1977, p. 846)

Overview of Applied Kohlberian Research

Considerable psychological and educational literature is available on the subject of moral development. The

works of Kohlberg (1969, 1972, 1973a, 1973b) present an extensive analysis of this cognitive-developmental process. According to the theorist, individuals make decisions based on their level of moral development. The six separate stages reflecting thinking or reasoning about ethical or moral problems follow an invariant sequence. In each successive stage the individual's reasoning ability becomes more differentiated, more integrated, and more universal. Research reported by Kohlberg and Turiel (1971) determined that most adults in the United States operate between Stages 3 and 5. The investigators documented that there are certain age periods, such as adolescence or early adulthood, when individuals more readily make transitions to the next higher stage. Hall and Davis (1975) stated that once an individual has attained a higher stage of moral reasoning, he will not lose this orientation even though occasionally lower stages may be reflected in certain responses.

Cross-cultural research using the Kohlberian interview format has determined that the ideal for principled thinking (reflected in in Stage 5 and Stage 6) to be the same for various cultures and eras. Research indicated that

the ideal is admired by all individuals of the culture and, therefore, not limited to those already functioning at the postconventional level (Kohlberg & Turiel, 1971).

Influenced by the research of Kohlberg (1969, 1972, 1973a, 1973b), Rest (1974) constructed the Defining Issues Test. This instrument measures how individuals differentiate the crucial moral issues in hypothetical dilemmas. Extensive research with the Defining Issues Test and subsequent analysis of developmental data trends have identified age and educational level as the most powerful demographic correlates of moral judgment (Crisham, 1981). Rest (1979) presented supportive evidence of the effect of intellectual milieu on the level of moral reasoning. Individuals exposed to situations where others are operating at higher levels of thinking may be stimulated to advance to a successive stage of reasoning (Rest, 1979).

Selected Research on Moral Development in Nurses

Research in moral development of nurses is emerging. Munhall (1979) conducted a study determining differences in levels of moral reasoning of baccalaureate nursing students in different academic years of their nursing education and their nursing faculty. Using Kohlberian

theory and the Defining Issues Test (Rest, 1974) results demonstrated baccalaureate nursing students to be operating within the conventional level of moral reasoning. No significant differences in moral reasoning occurring among the 4 academic years were observed. Nursing faculty, on the average, was operating within a principled level of moral reasoning, stressing the application of conscience and universal ethical principles when thinking about moral dilemmas.

An earlier study by Murphy (1976) investigated differences in levels of moral reasoning among nurses in different types of working environments and in different positions of authority. The Kohlberian standardized interview format presenting hypothetical moral dilemmas was administered to a group of 30 public health staff nurses, 30 public health supervisors, 30 hospital staff nurses, and 30 hospital head nurses. Analysis of variance for the effect of environment and position of authority on levels of moral reasoning revealed no significant differences. Findings determined most of the participants to be operating at the conventional level of moral reasoning which stresses obedience to authority and the need for harmonious relationships with social institutions

and authority figures. Only 5% of the sample of 120 nurses used Stage 5 thinking as their modal stage of cognitive reasoning.

Schoenrock (1978) randomly sampled generic baccalaureate nursing programs in Texas to determine moral reasoning levels of nursing students and practicing graduates. Data obtained from the Defining Issues Test (Rest, 1974) were treated by t-test for independent samples and chi-square analysis. Results demonstrated that baccalaureate nursing students operated at the preconventional level, the conventional level, and the postconventional level. Equal numbers of nurses were found at the conventional and postconventional levels while almost 10% of the student sample operated at the premoral or preconventional level. Furthermore, results demonstrated that most nursing practitioners operated at the postconventional range (14 of 26 or 54%). Two subjects (8%) operated at the premoral or preconventional level. The finding that nursing students and nursing practitioners were at all three levels of moral reasoning implicated the need in Texas to develop curricula designed to encourage development of more principled moral thinkers (Schoenrock, 1978).

In a descriptive study by Ketefian (1981), a sample of 79 registered nurses from three acute care medical facilities was administered the Defining Issues Test and the Watson-Glaser Critical Thinking Test. Findings demonstrated that critical thinking was significantly correlated with moral judgment ($r = .5326$, $p = .001$). Differences between moral judgment of professional and technical nurses was tested by one-way analysis of variance. Findings revealed that nurses who had professional education had more advanced levels of moral reasoning than those who had received technical nursing preparation ($F_{1,77} = 9.644$, $p < .01$). Other findings demonstrated that critical thinking and educational preparation together predicted greater variance in moral judgments than either variable alone, which was tested through multiple regression analysis ($F_{2,75} = 18.3$, $p < .01$). Critical thinking and education together accounted for 32.9% of the variance in moral judgment. Additional statistical analysis between moral judgment and demographic variables such as age, religion, and ethnicity did not yield noteworthy results.

An instrument specific to the measurement of moral judgement in nursing dilemmas which were taken from actual

clinical situations was developed by Crisham (1981). This instrument, the Nursing Dilemma Test, measures nurses' responses to nursing dilemmas and the importance given to moral issues and practical considerations. Initially, Crisham investigated the differences between staff nurses' responses to nursing dilemmas in the Nursing Dilemma Test and responses to hypothetical moral dilemmas in the Defining Issues Test (Rest, 1974). Responses were compared to level of nursing education and to length of clinical nursing experience. Findings determined the nursing principled thinking scores (NP) increased with education; the group with the highest level of education also had the highest NP scores. This finding corroborates previous research that cognitive restructuring of moral thinking is positively related to level of formal education (Ketefian, 1981; Rest, 1979).

The practical considerations (PC) score, indicating the relative importance given to practical considerations, was significantly higher in nurses with more clinical experience than those with less clinical experience. High PC scores in the more experienced nurses, however, did not reflect an associated high score on the nursing principled thinking scale. This finding indicated partial evidence of the milieu effect on moral judgments. Finally, subjects

who indicated familiarity with ethical dilemmas presented in the Nursing Dilemma Test scored higher on the nursing principled thinking scale than those subjects unfamiliar with the dilemmas. The investigator concluded that formal education and previous deliberation about real-life nursing dilemmas appeared to be associated with the way nurses judge moral issues (Crisham, 1981).

Summary

This chapter has presented literature considered supportive to the investigation of nurses' values and their perceptions of ethical responsibility in nursing practice. The reported research on the study of values in nurses revealed variable findings. Studies utilizing the Allport-Vernon-Lindzey Study of Values (Allport et al., 1970) determined that nurses most often scored highest on social values. These studies were performed primarily on student nurses; studies performed on their instructors revealed that highest scores obtained were on theoretical values and aesthetic values. A consistent profile in all studies was apparent on the scores reflecting economic values and political values. In general, the literature determined that nurses consistently scored lowest on economic values and political values.

Research reporting the investigation of moral development in nurses was also discussed. The paucity of studies in this area prevents a firm conclusion as to the level of moral reasoning in nurses. Although all levels of moral reasoning were observed in the nurses studied, the conventional level was determined as the level at which most of the nurses operated. This level reflects both Stage 3 and Stage 4 thinking. In general, the variables of age, level of formal education, and the effect of intellectual milieu were found to be positively correlated with the level of moral reasoning in the nurses studied. This finding corroborated previous research in the educational and psychological fields.

CHAPTER 3

PROCEDURE FOR THE COLLECTION AND TREATMENT OF DATA

A descriptive-correlational study was conducted utilizing a survey approach as the method of obtaining data. The primary purpose of the study was to determine the relationship between selected values of nurses and the nurses' perception of ethical responsibility in nursing practice. This chapter is concerned with the methodological elements employed to investigate this relationship.

Setting

No specific setting was determined. The setting included all the states of the United States and provinces of Canada as determined by participant residence. The possibility existed that a participant held citizenship in another country.

Population and Sample

The population for this study was all members of the Oncology Nursing Society who met the designated criteria for this study. The Oncology Nursing Society

is a multinational organization for registered nurses. Membership at the 1980 Annual Congress of the Oncology Nursing Society exceeded 2,500 members (Oncology Nursing Forum, 1981). Approximately 1,500 members were in clinical practice. The sample for this study was obtained by using a random systematic sampling technique. This non-biased technique employed a percentage factor dividing the size of the overall sample with the size of the intended sample to obtain a factor for randomized sampling ($\underline{N} \div \underline{n} = \underline{kth}$) (Polit & Hungler, 1978). For the purposes of this study an intended sample of 200 clinical oncology nurses was discerned. An alphabetically compiled membership directory was utilized. Every 13th member with a listed clinical focus was selected for eligibility into the study ($2,500 \div 200 = 12.5$).

Nurses who participated in this study met the following criteria:

1. Licensure in at least one of the states of the United States or the provinces of Canada.

2. Chronological ages between 18 to 65 years.

3. Fluency in the English language.

4. Participants were currently employed in clinical nursing practice.

Protection of Human Subjects

The components of this research fell within the guidelines of Category I (no risk) of the Federal Register published Monday, January 26, 1981, Part X, effective July 27, 1981. Written permission to conduct the study was obtained from the Human Research Review Committee at Texas Woman's University (Appendix A) and from the Provost of the graduate school (Appendix B). The inherent rights of privacy, anonymity, and confidentiality were expressed to each subject in an introductory letter of explanation (Appendix C). The return of completed questionnaires was construed as informed consent to participate in the study.

Instruments

Three instruments were used in this study. The first was the Allport-Vernon-Lindzey Study of Values: A Scale for Measuring the Dominant Interests in Personality (Allport et al., 1970) (Appendix D). This scale was first published in 1931 and revised in 1951. It assesses the relative prominence of six basic interests or motives of personality: theoretical, economic, aesthetic, social, political, and religious values. Personalities are best determined through a study of values.

The authors reported that completion time is approximately 20 minutes (Allport et al., cited in Buros, 1978). The two-part test consists of a number of questions based on familiar situations. There is a total of 120 answers; 20 of these questions refer to each value.

Scoring is simplified by an ingenious arrangement of answer spaces. The subject writes a number indicative of his preferred response in each answer space. The numbers are tabulated according to simple instructions which are printed on the last page of the test booklet. Total scores on the six values must be equal to 240, thus making 40 the mean score for each individual value. Final scores reflect only relative strength in the six areas, making it impossible to obtain high or low scores in all areas. All areas are arranged in random order in the test booklet, giving no clue as to the value categories to which they will be scored.

The internal consistency of this instrument was determined by two methods:

1. Split-half reliability coefficient, using a z transformation, yielded a mean reliability of .90. Each of the basic interests has a reliability as follows: "theoretical .84, economic .92, aesthetic .89, social

.90, political .87, and religious .95" (Allport et al., 1970, p. 9). These data were obtained from a sample of 100 subjects.

2. Item analysis showed a positive correlation for each item with the total score for its corresponding value, significant at the .01 level of confidence. These data were obtained from a group of 780 subjects of both sexes from six different colleges (Allport et al., 1970).

The external validity of the scale was established from the scores of groups whose characteristics were known. The scale has been used widely and has had particular utility with college students in the liberal arts and with adults with college experience (Robinson & Shaver, 1973). Validity data in the manual consist mainly of showing that educational and occupational groups have value patterns as might be expected (Allport et al., 1970).

The variable "perceived ethical responsibility" was measured by the Nursing Dilemma Test (Appendix E). This tool, developed in 1978 by Crisham, was fashioned after the Defining Issues Test by Rest (1974) and serves as a summated rating scale yielding data at the interval level of measurement. Permission was obtained for use of this tool (Appendix F). The original development of this

tool was designed to measure (a) nurses' responses to recurrent dilemmas and the importance given to moral or ethical issues (NP or nursing principled thinking score), (b) nurses' responses to recurrent dilemmas and the importance given to practical considerations (PC score), and (c) nurses' familiarity with ethical dilemmas (F score). The ethical dilemmas categorized in this test include: "Newborn with Anomalies," "Forcing Medication," "Adult's Request to Die," "New Nurse Orientation," "Medication Error," and "Terminally Ill Adult."

This instrument was administered to 146 staff nurses with associate, baccalaureate, or master's degrees, to 38 college junior prenursing students, to 38 graduate level non-nurses, and 10 expert nurses which comprised the total sample of 232 subjects. Rankings of scores on the Nursing Dilemma Test were as follows: the item ranked as most important with each dilemma was given 6 points; the item ranked second was given 5 points; the item ranked third was given 4 points; the item ranked fourth was given 3 points; the item ranked fifth was given 2 points; the item ranked sixth was given 1 point. The NP score was calculated by adding

the scores of the NP items across the six dilemmas. The NP index represents the sum of weighted ranks given to principled items and is interpreted as the relative importance given to principled moral considerations in making a nursing moral decision. The highest possible NP score is 66 with two NP items for each of the dilemmas.

A similar ranking process assessed the practical considerations (PC) score. The PC score was calculated by adding the scores of items that represented practical considerations across the six dilemmas. The PC index represents the sum of weighted ranks given to practical considerations and is interpreted as the relative importance given to practical considerations in making a nursing moral decision. The highest possible PC score is 36 with one PC item for each dilemma.

The familiarity with ethical dilemmas score (F) was calculated by adding the points that indicated the subject's previous degree of involvement with similar dilemmas across the six dilemmas. The F index represents the sum of the subject's indication of degree of involvement with similar dilemmas. The classification of the subject as unfamiliar or familiar with the dilemmas was based on

the properties of the F scale; a score of 6 through 17 indicated familiarity with the dilemmas, and a score of 18 through 30 indicated unfamiliarity with the dilemmas (Crisham, 1981).

The recent development of this tool precludes extensive evaluation to measure its validity and reliability. Crisham reported that further content, criterion-related, and construct validity in this instrument was needed. In the initial testing of the Nursing Dilemma Test, Cronbach's alpha was used to assess the internal consistency reliability coefficient across dilemmas. The alpha (n = 225) for the practical considerations score (PC) was .39, the alpha (n = 225) for the nursing principled thinking score (NP) was 57. Crisham suggested that using only three of the possible six rankings would yield a higher reliability.

The third instrument, the Subject Profile (Appendix G), was developed by the investigator. This instrument obtained descriptive information concerning the sample including subjects' age, marital status, sex, highest educational level, religious affiliation, importance given to religious affiliation, and number of years in nursing practice. The data were used for descriptive purposes and to provide a comparative analysis of other samples.

Data Collection

All data were obtained from written responses to the Subject Profile, the Allport-Vernon-Lindzey Study of Values, and the Nursing Dilemma Test. A sample size of 192 nurses meeting the study criteria was initially discerned. Each eligible participant was assigned a study identification number. A mailing list was compiled and a coding scheme was utilized to protect the participant's confidentiality and to organize the data returns. A questionnaire packet was mailed to each of the participants, utilizing the services of the United States Postal Service. The packet contained an introductory explanatory cover letter, the Subject Profile, the Study of Values, and the Nursing Dilemma Test. Instructions for completion of the measurement scales and for the process of their return to the investigator was also included in the letter of explanation. A stamped, self-addressed envelope was included to encourage an efficient response.

Upon receipt of a large number of unused, non-deliverable questionnaires, a second mailing to 40 eligible participants was undertaken. A random sampling technique was employed in the identical manner as for the initial sample. The final sample was comprised of 232 nurses meeting the study criteria.

Treatment of Data

The demographic data to describe the study sample were tabulated. The respondents' scores on the Study of Values were hand-tallied by the investigator according to the Allport-Vernon-Lindzey Study of Values Manual (Allport et al., 1970). Initial interpretation of the scores on the Study of Values was obtained by comparing the respondents' scores with those norms established by Allport et al. (Appendix H). The respondents' scores on the Nursing Dilemma Test were hand-tallied by the investigator according to instructions provided by Crisham (Note 1). A Nursing Dilemma Test Key (Appendix I) which has been copyrighted by Crisham (1978) was utilized in the scoring process.

The four hypotheses were subjected to testing through the use of a multiple-linear regression technique. This method determines the effect of two or more independent variables on a dependent measure (Polit & Hungler, 1978). The degree to which the independent variables influence the dependent measure served as the predictive factor of the correlation among the multiple variables. The .05 significance level was used as the acceptable critical value for the study. All computerized

statistics were obtained through the services of the Statistical Package for the Social Sciences.

CHAPTER 4

ANALYSIS OF DATA

A descriptive-correlational study was conducted to determine the relationship between selected values of nurses and the nurses' perception of ethical responsibility in nursing practice. This chapter is concerned with an analysis of data gathered from the Allport-Vernon-Lindzey Study of Values, the Subject Profile, and the Nursing Dilemma Test. Forty-six oncology nurses were involved as subjects in this investigation. Data collected from the sample are presented and interpreted in this chapter. Statistically significant findings are shown in terms of the subjects' responses on the instruments. Summary statements of the findings are also included.

Description of Sample

Questionnaire packets containing an introductory letter of explanation, Study of Values, Nursing Dilemma Test, and Subject Profile were mailed to 232 oncology nurses. Forty-six questionnaire packets were returned unopened by the United States Postal Service and declared

undeliverable. A total of 64 respondents returned questionnaire packets to the investigator. Eighteen questionnaire packets were rejected by the investigator due to item omission (8), test omission (2), and Subject Profile omission (8). A total of 122 questionnaire packets were never returned to the investigator. The resulting 46 questionnaire packets determined the sample size of respondents.

The final sample consisted of 46 oncology nurses who were selected from an international membership directory of the Oncology Nursing Society. The method of sampling was random and systematic. All subjects were female. Forty-four subjects were employed as registered nurses in the United States. Two subjects were employed as registered nurses in Canada. All subjects were in clinical oncology nursing positions.

Demographic data to describe the sample were age, marital status, highest nursing educational level, sex, number of years in nursing practice, preferred religious affiliation, and the importance placed on preferred religious affiliation. The mean age of the subjects was 38.5 years with a range from 25-66 years. Over one-half (57%) of the sample was married, 28% was

single, and 15% was divorced. The sample represented all levels of nursing education including the diploma, associate, bachelor's, master's, and doctoral degrees. Seventy percent of the sample had either a bachelor's or master's degree in nursing.

Over one-half of the sample (53%) had been in nursing practice between 10 and 20 years. An additional 24% of the sample displayed a range of 20 to 30 years in nursing practice. The remainder of the sample had either been in nursing practice for over 30 years (4%) or for less than 10 years (18%). One subject did not report the number of years in nursing practice.

The sample represented a variety of religious affiliations. Thirty-nine percent of the sample was Catholic. Twenty-six percent of the sample was Protestant. Presbyterian and Lutheran religious preferences were equally distributed in the sample (7%). The remainder of the sample represented Christian, Unitarian, Jewish, Anglican, Evangelican, Congregational, or no religious preferences.

Findings

Two instruments were used in the study to test the hypotheses. The first, the Allport-Vernon-Lindzey Study of Values, supplied data on the independent or predictor variables. Six single scores were obtained to correspond with the six values under investigation. These values were Theoretical (T), Economic (E), Aesthetic (A), Social (S), Political (P), and Religious (R). Mean scores and standard deviations for each of the six values are given in Table 1.

Table 1

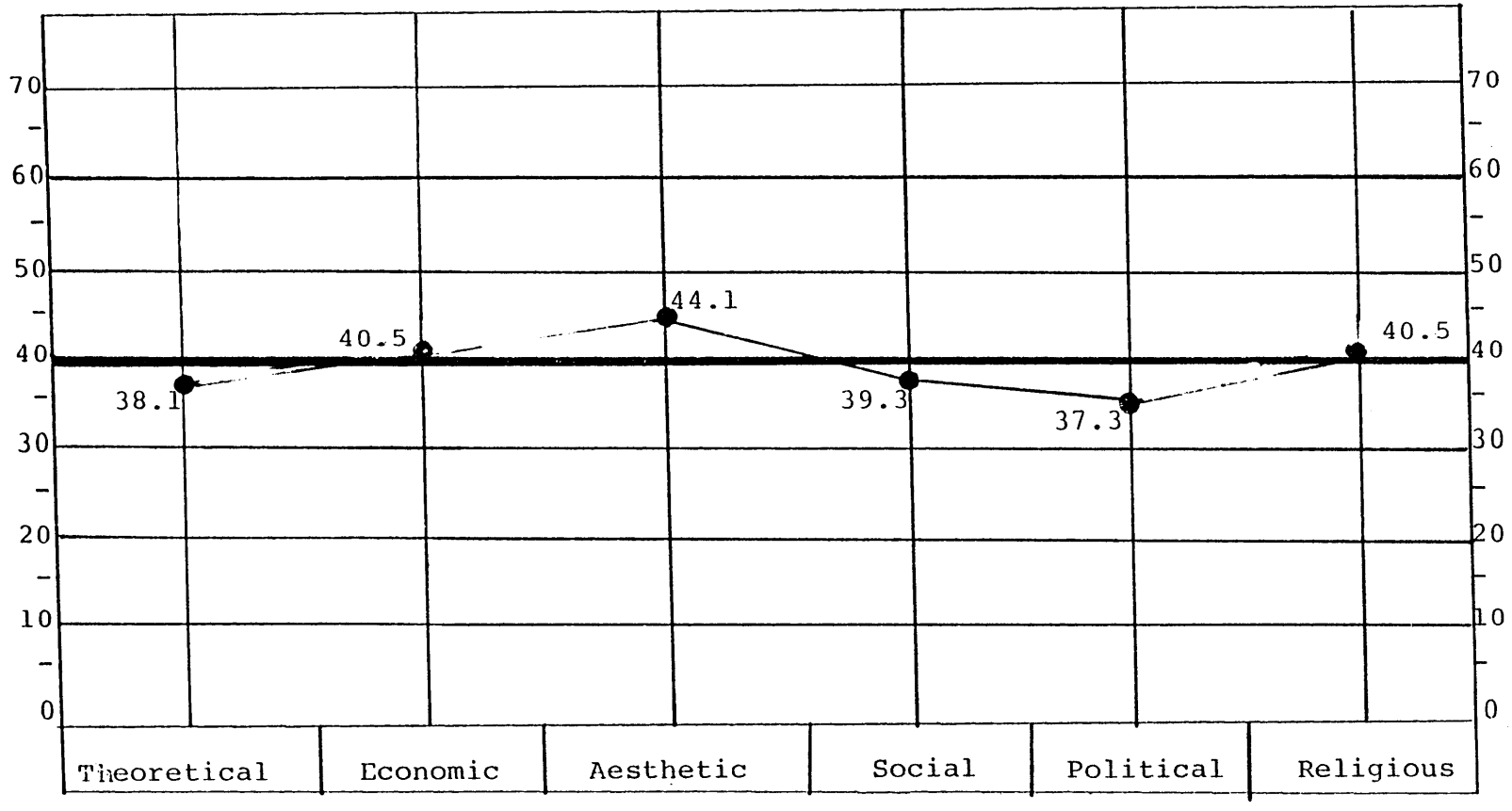
Subjects' Scores for the Six Value Types
Allport-Vernon-Lindzey Study
of Values

Variable	Mean	Standard Deviation
Aesthetic Value (A)	44.1	5.92
Economic Value (E)	40.5	6.91
Religious Value (R)	40.5	9.59
Social Value (S)	39.3	7.20
Theoretical Value (T)	38.1	5.52
Political Value (P)	37.3	5.77

$n = 46$.

The mean scores on each value are plotted in a style similar to that provided on the Allport-Vernon-Lindzey Study of Values to form a value profile for the sample group. Figure 1 depicts the sample's value profile. The profile revealed that the sample scores on aesthetic, economic, and religious values were below the mean score of 40 as determined by Allport et al. (1970). Scores reflecting values below the mean of 40 were observed in the social, theoretical, and political values. The highest mean score (44.1) represented aesthetic values. The lowest mean score (37.3) represented political values.

The second instrument, the Nursing Dilemma Test, obtained data on the dependent or criterion variables. Three single scores and one composite score were obtained. The single scores obtained were the nursing principled thinking score (NP), the practical considerations score (PC), and the familiarity with ethical dilemmas score (F). The composite score was obtained through summation of the three single scores. The composite score measured the subjects' perception of ethical responsibility (ER). The nursing principled thinking mean score revealed that the sample was operating at a postconventional level of moral



Note. 50-70 = high; 40 = average; 10-30 = low.

Figure 1. Profile of Subjects' Values

reasoning. Subjects' scores for each of the four scores are presented in Table 2.

Table 2

Possible Range, Means, and Standard Deviations for Scores Measuring Perceived Ethical Responsibility on the Nursing Dilemma Test

Variable	Possible Range	Mean	Standard Deviation
Nursing Principled Thinking (NP)	18-66	59.630	4.841
Practical Considerations (PC)	6-36	19.391	3.389
Familiarity with Ethical Dilemmas (F)	6-17	12.000	3.148
Composite score (ER)	30-119	86.021	6.734

$n = 46$.

Hypothesis 1 stated: There are no significant relationships between the composite score measuring perceived ethical responsibility as measured by the nursing principled thinking score, the practical considerations score, and the familiarity with ethical dilemmas score on the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of

Values. The statistical technique used to test the hypothesis was multiple regression. The independent or predictor variables were the theoretical, economic, aesthetic, social, political, and religious values. The composite score on the Nursing Dilemma Test which measured perceived ethical responsibility was the dependent or criterion variable.

Statistical analysis revealed that Economic Values (E) and Political Values (P) were significantly correlated in an inverse direction with the score measuring perceived ethical responsibility (ER). The computed multiple R statistic was .399 and was significantly correlated at $p < .025$. A summary of the regression statistics using Economic Values (E) and Political Values (P) as predictors is shown in Table 3.

Furthermore, the equation

$$ER = -.285\ (E) + -.309\ (P) - 109.12$$

can be used to predict the ethical responsibility score (ER). The computed coefficient of determination (R^2) indicated that 16% of the variability in the ER score is accounted for by Political Values (P) and Economic Values (E) combined. In order to demonstrate the relative strength attached to each of the predictor variables, the beta weights were examined. The predictor

Table 3

Analysis of Variance for Multiple Regression:
Economic Values, Political Values,
and Ethical Responsibility

R	R^2	df	Sum of Squares	Mean Square	F	p
		regression 2	324.952	162.476		
.399	.159	residual 43	1716.025	39.907	4.071	< .025

variable with the higher beta weight was Economic Values (E) (-0.292). This signified that economic values were better predictors of ethical responsibility than are political values. Sets of beta weights for prediction and associated statistics are displayed in Table 4.

Hypothesis 1 stated that there are no significant relationships between the composite score measuring perceived ethical responsibility as measured by the nursing principled thinking score, the practical considerations score, and the familiarity with ethical dilemmas score on the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values. The null hypothesis was rejected at the .025 level of significance. The inference for the sample in this study was that an inverse relationship existed between nurses' perceived ethical responsibility using nursing principled thinking, practical considerations, and familiarity with ethical dilemmas and the nurses' economic and political values. The inverse relationship depicted that the lower the economic value and political value scores, the higher the ethical responsibility score. Furthermore, economic values were better

Table 4

Summary Table of *Beta* Weights for Two Regressions

Independent Variable	*R*	R^2	*B*	*beta*	Standard Error *B*	*F*
Economic Value (E)	.399	0.159	-0.285	-0.292	0.136	4.380
Political Value (P)			-0.309	-0.265	0.163	3.592
Constant			109.121			

p < .025.

predictors of this inverse correlation than were political values.

Hypothesis 2 stated: There are no significant relationships between the single score measuring nursing principled thinking as measured by the NP score of the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values. The statistical technique used to test Hypothesis 2 was multiple regression. The independent or predictor variables were the theoretical, economic, aesthetic, social, political, and religious values. The nursing principled thinking score (NP) was the dependent or criterion variable.

Statistical analysis revealed that the Economic Value (E) score was significantly correlated in an inverse direction with the score measuring nursing principled thinking (NP). The computed coefficient of multiple correlation (R) was .294 and was significantly correlated at $p < .05$. Table 5 presents the analysis of variance to determine the significance of the multiple regression of these correlates.

The multiple regression equation

$$NP = -.026 (E) + 62.962$$

Table 5

Analysis of Variance for Multiple Regression:
Economic Value and Nursing
Principled Thinking

R	R^2		df	Sum of Squares	Mean Square	F	p
		regression	1	91.074	91.074		
0.293	.086	residual	44	963.642	21.900	4.158	< .05

can be used to predict the nursing principled thinking score (NP). The computed coefficient of determination ($\underline{R}^2$) indicated that 8.6% of the variability in the NP score is accounted for by the Economic Value (E) score.

Hypothesis 2 stated there are no significant relationships between the single score measuring nursing principled thinking as measured by the NP score of the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values. The null hypothesis was rejected at the .05 level of significance. The inference for the sample in this study was that an inverse relationship existed between nursing principled thinking and the nurses' economic values. The inverse relationship depicted that the lower the economic value score, the higher the nursing principled thinking score.

Hypothesis 3 stated: There are no significant relationships between the single score measuring practical considerations as measured by the PC score on the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values. The statistical technique used to test the hypothesis

was multiple regression. The independent or predictor variables were the theoretical, economic, aesthetic, social, political, and religious values. The practical considerations score (PC) was the dependent or criterion variable. Statistical analysis revealed no significant correlations between the PC score and the six values ($F_{1,44} = 2.00$, $p = .163$).

Hypothesis 3 stated there are no significant relationships between the single score measuring practical considerations as measured by the PC score on the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values. The null hypothesis was not rejected at the .05 level of significance.

Hypothesis 4 stated: There are no significant relationships between the single score measuring familiarity with ethical dilemmas as measured by the F score on the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values. The independent or predictor variables were the theoretical, economic, aesthetic, social, political, and religious values. The familiarity

with ethical dilemmas score (F) was the dependent or criterion variable.

Statistical analysis revealed that the Political value score (P) was significantly correlated in an inverse direction with the familiarity with ethical dilemmas score (F). The computed coefficient of multiple correlation (R) was .333 and was significant for $p < .025$.

Table 6 presents the analysis of variance to determine the significance of the multiple regression of these correlates. The multiple regression equation

$$F = -.128\ (P) + 18.779$$

can be used to predict the familiarity with ethical dilemmas score (F). The computed coefficient of determination (R^2) indicated that 11% of the variability in the familiarity with ethical dilemmas score (F) is accounted for by the Political Value score (P).

Hypothesis 4 stated there are no significant relationships between the single score measuring familiarity with ethical dilemmas as measured by the F score of the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values. The null hypothesis was rejected at the .05 level of significance. The inference for the

Table 6

Analysis of Variance for Multiple Regression: Political Value and Familiarity with Ethical Dilemmas

R	R^2	df	Sum of Squares	Mean Square	F	p
		regression 1	49.374	49.374		
.332	0.110	residual 44	396.625	0.014	5.477	< .025

sample in this study was that an inverse relationship existed between nurses' familiarity with ethical dilemmas and the nurses' political values. The inverse relationship depicted that the lower the political value score, the higher the familiarity with ethical dilemma score.

Additional Findings

Additional statistical analysis using multiple regression technique was used to test the relationship between selected demographic variables and the composite score measuring perceived ethical responsibility. The demographic variables of age, highest level of nursing education, and number of years in nursing practice were the independent or predictor variables. The dependent or criterion variable was the composite score measuring perceived ethical responsibility. Statistical analysis revealed no significant correlations ($F_{1,44} = 3.283$, $p = .077$) between subjects' age, highest level of nursing education, number of years in nursing practice, and subjects' perceived ethical responsibility.

Summary of Findings

The findings of this study are summarized as follows:

1. Perceived ethical responsibility significantly correlated in an inverse direction with economic and political values. Economic values are better predictors of ethical responsibility than are political values.

2. Nursing principled thinking significantly correlated in an inverse direction with economic values.

3. There were no statistical relationships between practical considerations and theoretical, economic, aesthetic, social, political, and religious values.

4. Familiarity with ethical dilemmas was significantly correlated in an inverse direction with political values.

5. Aesthetic values were ranked most important in the sample. Political values were ranked as least important in the sample.

6. A postconventional level of moral reasoning was found in the sample.

7. There were no statistical relationships between ethical responsibility and age, highest level of education, and number of years in nursing practice.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter provides a summary of the study and discusses the findings. Conclusions and implications based on the findings are followed by recommendations for further study in relation to nursing research, nursing education, and nursing practice.

Summary

The problem of this descriptive-correlational investigation was to determine the relationship between theoretical, economic, aesthetic, social, political, and religious values of nurses and the nurses' perception of ethical responsibility in nursing practice. Additionally, the research studied the relationships between theoretical, economic, aesthetic, social, political, and religious values of nurses and the level of nursing principled thinking, the importance given to practical considerations, and familiarity with ethical dilemmas. Allport's (1955, 1959, 1961) concept of values from his theory of personality and Kohlberg's (1969, 1972, 1973a, 1973b). theory of cognitive-developmental level of moral

reasoning provided the theoretical framework for the study.

The sample of the study included 46 female oncology nurses randomly selected from a membership directory of the Oncology Nursing Society. All subjects were registered nurses and employed in a clinical nursing setting in one of the states of the United States or provinces of Canada.

Subjects provided written responses to three instruments which were mailed to them by the investigator of the study. The Study of Values provided data on the independent or predictor variables. This objective test yielded six individual scores reflecting the relative importance given to theoretical, economic, aesthetic, social, political, and religious values as they were originally defined by Allport et al. (1970). The Nursing Dilemma Test provided data on the dependent or criterion variables. Subjects responded to six dilemmas titled "Newborn with Anomalies," "Forcing Medication," "Adult's Request to Die," "New Nurse Orientation," "Medication Error," and "Terminally Ill Adult." The Nursing Dilemma Test yielded the nursing principled thinking (NP) score, the practical considerations (PC) score, and the familiarity with ethical dilemmas (F) score. A fourth

score was derived through summation of the three scores and provided measurement of the perception of ethical responsibility. The Subject Profile instrument identified selected demographic characteristics of the sample. The mean scores for the six value indices and for the indices measuring perceived ethical responsibility were reported for descriptive purposes.

Four null hypotheses were formulated for the study:

1. There are no significant relationships between the composite score measuring perceived ethical responsibility as measured by the nursing principled thinking score, the practical considerations score, and the familiarity with ethical dilemmas score on the Nursing Dilemma Test and the nurses' individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

2. There are no significant relationships between the single score measuring nursing principled thinking as measured by the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

3. There are no significant relationships between the single score measuring practical considerations as

measured by the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

4. There are no significant relationships between the single score measuring familiarity with ethical dilemmas as measured by the Nursing Dilemma Test and the individual scores measuring theoretical, economic, aesthetic, social, political, and religious values on the Study of Values.

Descriptive statistical analyses determined highest sample mean scores on aesthetic values and lowest mean scores on political values. Furthermore, high mean scores on nursing principled thinking revealed the sample to be operating near the postconventional level of moral reasoning.

Linear regression analysis was performed on the multiple independent and dependent variables. Three of the four null hypotheses were rejected at the .05 level of significance. Statistically significant findings revealed that economic values and political values of nurses were inversely correlated with the scores measuring perceived ethical responsibility. Economic values of nurses were

inversely correlated with the use of nursing principled thinking. Political values of nurses were inversely correlated with the degree to which nurses were familiar with ethical dilemmas. Additional regression analysis revealed no significant correlations between the subjects' age, highest level of nursing education, and the number of years in nursing practice and the subjects' scores measuring perceived ethical responsibility.

The findings of the study are summarized as follows:

1. Perceived ethical responsibility significantly correlated in an inverse direction with economic and political values. Economic values are better predictors of ethical responsibility than are political values.

2. Nursing principled thinking significantly correlated in an inverse direction with economic values.

3. There were no statistical relationships between practical considerations and theoretical, economic, aesthetic, social, political, and religious values.

4. Familiarity with ethical dilemmas was significantly correlated in an inverse direction with political values.

5. Aesthetic values were ranked most important in the sample. Political values were ranked as least important in the sample.

6. A postconventional level of moral reasoning was found in the sample.

7. There were no statistical relationships between ethical responsibility and age, highest level of education, and number of years in nursing practice.

Discussion of Findings

For the convenience of the reader, the findings of the study are discussed individually in the order of presentation.

1. A finding of the present study was that ethical responsibility of nurses increased in the face of decreasing importance ascribed by nurses to their economic and political values. Conversely, as the relative importance of economic and political values was deemphasized by nurses, their perception of ethical responsibility was enhanced. Interpretation of this finding is necessarily speculative. Apparently, this sample of nurses did not seem to place a high value on economic pursuits such as usefulness, practicality, or the acquisition of material goods for self. Additionally, nurses apparently considered political pursuits such as personal power, leadership, authority, and renown to be of low importance. Interestingly, the lower the

importance given to their economic and political values combined, the greater was their perception of ethical responsibility in their nursing practices. This finding suggested some congruency with the humanitarian perspective advocated by nurses in which their concerns for the welfare of others is deemed superior to the materialistic needs of self. The possibility exists, contrary to the present demands made by some nurses for higher pay, more leadership, and greater professional autonomy, that nurses plainly do not hold as part of their value system these economic and political pursuits. This possibility is reported with some caveats for interpretation, however. The low variabilities obtained in the economic and political values of nurses as predictive factors for the nurses' perception of ethical responsibility suggested that many other factors in addition to values are instrumental in predicting ethical responsibility.

2. Another finding of this research was that as the use of principled thinking by nurses increased, there was a corresponding decrease in the relative importance ascribed to economic values. Nursing principled thinking is a reflection of postconventional moral reasoning and as such reflects thinking which abides by social norms

representing universal principles of justice, fairness, and reciprocity (Crisham, 1981; Kohlberg, 1973b). Use of nursing principled thinking involves a humanistic concern for the welfare of others; this concern is based on the autonomous and egalitarian view of the nurses' professional role. Accordingly, the nurse using a principled level of moral reasoning questions the ethical basis for judgments made on behalf of others. The concerns for practicality, usefulness, and materialistic advantages clearly were de-emphasized factors in the nurses' ethical reasoning involving patient centered principles of justice and fairness. Although nurses' economic values are, therefore, predictive of the use of nursing principled thinking, the low variabilities obtained suggested that many undetermined factors are instrumental in this relationship.

3. Another finding of this study was that there were no statistical relationships between nurses' values and the importance they ascribed to practical considerations. Examples of practical considerations pertinent to the nurses' milieu included: time allotment; availability of health team; the physical structure of the health institution; and the rules, procedures, and regulations prescribed by the health institution. These

external factors were not operational within the nurses' ranking of their theoretical, economic, aesthetic, social, political, or religious values. This finding suggested that consideration of practical aspects of a situation is not an influential component of internalized personal values ranking among nurses.

4. Additionally, this research determined that as nurses' familiarity with ethical dilemmas increased, there was an associated decrease in the relative importance ascribed to political values. Nurses in this study were involved in varying levels of responsible leadership and advocacy, ranging from staff nurses to clinical specialists and clinical directors. The ethical dilemmas presented to the nurses in this study were familiar to them and many nurses reported having actually experienced similar dilemmas. The finding showed that possessing knowledge or information about ethical dilemmas was not reflective of nurses' needs for personal power, authority, leadership, or renown. In fact, these pursuits were determined to be in opposition to the degree of familiarity with ethical dilemmas experienced. Further extrapolation from the definition supplied by Allport et al. (1970) determined that a political value orientation also included the concepts of competition

and struggle. Competition and struggle are ubiquitous concerns for individuals motivated by the pursuit of personal power or influence. Additionally, however, competition and struggle play a large part in all life situations and may be either direct or indirect determinants of behavior (Allport et al., 1970). This observation may be especially relevant to nurses functioning within a competitive society yet still advocating humanitarian beliefs. Regardless of the frequency in which they encountered struggles about ethical issues, the nurses in this sample de-emphasized pursuits of personal power. However, the low variabilities obtained in political values as determinants of the nurses' familiarity with ethical dilemmas suggested that many unknown factors are instrumental in this relationship.

5. Another finding of this study revealed that clinical oncology nurses ascribed greatest importance to aesthetic values. According to the definition supplied by Allport et al. (1970), the aesthetically oriented individual places high regard on artistic form and harmony and displays an interest in self-sufficiency rather than in the social welfare of other persons. This finding is consistent with research involving clinical

nursing instructors (Redman, 1966). However, this finding is inconsistent with research involving student nurses which reported highest rankings on either religious values (Brand, 1967; Dustan, 1964; Gortner, 1968; May & Ilardi, 1970; Redman, 1966; Smith, 1968) or social values (Garvin, 1976). Although aesthetic values were ranked as those which were most important to clinical oncology nurses, aesthetic values were not correlates of perceived ethical responsibility.

In general, all previous research studied identified that student nurse populations scored lowest on political values and economic values. The findings of this study revealed that clinical oncology nurses ascribed least importance to political values. According to the definition of political value types supplied by Allport et al. (1970), the inference is that little importance was rendered to pursuits of personal power, authority, leadership, and renown.

An interesting observation was noted in the general value profile characterized by this sample (Figure 1). Although the clinical oncology nurses presented a mean age of 38 years, their value profile was remarkably similar to the value profile of female college students established by Allport et al. (1970) (Appendix H). A

plausible reason for this similarity is suggested by the theoretical notion developed by Allport et al. According to the theorists, values are personal dispositions or intentions that are internalized and integrated by the individual as one researches maturity or adulthood. Further extrapolation of the theory suggested that the similarity of the two value profiles indicated a consistency of female value preferences rather than a comparison of value preferences of female nurses with female college students.

6. A general finding relative to the level of moral reasoning was indicated by the data. The score measuring the use of nursing principled thinking also determined the Kohlberian stages of postconventional moral reasoning (Crisham, 1981). The possible range of NP scores which reflected Stages 5 and 6 thinking was 66; the mean score obtained by the nurses was 59.6. The close proximity of the mean score to the maximum score suggested that the nurses in this sample were operating near or within a postconventional level of moral reasoning. The nurses in the sample, therefore, were making judgments based on their conscience and the application of universal ethical principles. This level of reasoning among nurses was also observed by

Murphy (1976), Schoenrock (1978), and Munhall (1979); therefore, the finding of the current study supported previous research.

7. The general finding that age, highest level of nursing education, and the number of years in nursing practice were not determined to be significant correlates of perceived ethical responsibility was an important result. The reported research literature suggested that the most powerful and consistent correlates of moral judgment development have been age and the level of formal education (Crisham, 1981). This finding in the present study does not correlate with the research reported earlier. A possible interpretation of this finding is that there was little variability with regard to age and to level of education in this sample. Therefore, expected correlations with perceived ethical responsibility were necessarily minimal.

Conclusions and Implications

The following conclusions and implications were offered:

1. Perhaps a dichotomy is present between what nurses profess they value and that which they truly

value. If this is so, then tools must be developed to provide more sensitive and meaningful measurement of values particular to nurses.

2. Acceptance of a humanitarian perspective which is centered around the welfare of others may be in direct opposition to perspectives involving personal power or material gains which serve the needs of self. This opposition may be observed in the ethical choices and behavior of nurses advocating on behalf of the welfare of others. If this is so, nurses could benefit from educational programs aimed at increasing awareness of personal values and ethical decision systems.

3. Nurses seem to oppose economic pursuits such as usefulness, practicality, and the acquisition of material gain for self when making principled judgments about the welfare of others. The nursing profession, therefore, may wish to work toward acceptance rather than mere resignation of the existing dichotomy between economic pressures and humanitarian values.

4. Competition and struggle may have been operating within the subjects' thinking as they reflected on ethical responsibility in nursing dilemmas. Since nurses in the study were operating near the

postconventional level of moral reasoning, the nurses' decision choices were based on conscience and ethical principles, perhaps negating the necessity for valuing competition, struggle, personal power, authority, and political renown when making responsible ethical judgments. If nurses can be made aware of their use of principled reasoning and have this reasoning supported in educational and practice settings, then affective modeling of principled thinking should occur.

5. There is great variety and change observed in some of the values of nurse samples, particularly with regard to social, religious, and aesthetic values. Value preferences by nurse populations reported in research studies (Brand, 1967; Garvin, 1976; Redman, 1966) revealed changing and conflicting patterns with special reference to values considered most important.

These changes are perhaps accounted for by the prevailing individuation of personal dispositions present in a pluralistic society. These changes may be indicative of competing values within individuals and between groups; these competitions may evoke conflict with regard to personal values and professional behavior.

6. Nurses may continue in their efforts to reach for power, autonomy, and leadership and may applaud

the struggles of those who win renown and wealth, yet their pursuits in the end may be unattainable. Perhaps nurses do not possess a value system which places in high regard such economic or political orientations. This is an important observation of nurses in general but especially important in terms of the nurses' ethical responsibility. Knowledge of what nurses do not value is as contributory as knowledge of what nurses do value. Consequently, predictions of ethical responsibility of nurses can be referenced to the nurses' economic and political values even if these values are indifferently or negatively perceived.

Recommendations for Further Study

The following recommendations for further study were identified:

1. This study could be replicated using different populations of clinical nurses.

2. A similar study should be designed using other objective measurements of nurses' values. The Rokeach (1973) Value Survey is suggested. Different conceptualizations of personal and interpersonal values may yield contributory information for the prediction of ethical

responsibility by nurses confronted with ethical dilemmas.

3. A nursing tool specific for the sensitive measurement of interpersonal values of nurses should be developed.

4. A research attempt should be made to investigate and/or correlate nurses' values with actual outcome behavior indicative of responsibility arising in ethical dilemmas.

5. More purposeful study of values and value systems of nurses is necessary for the discovery of what nurses claim as central beliefs or dispositions.

APPENDIX A

Prospectus for Thesis
Approval Form

This proposal for a thesis by Michele Ann Carter, R.N., B.S.

and entitled

Values of Nurses and Their Perceptions of Ethical Responsibility

has been successfully defended and approved by the members of the Thesis Committee.

This research is xx is not _____ exempt from approval by the Human Subjects Review Committee. If the research is exempt ~~exempt~~, the reason for its exemption is: The components of this proposed research fall within the guidelines of category I (no risk) of the Federal Register, published Monday, January 26, 1981, Part X, effective July 27, 1981.

Thesis Committee: Helen A. Bush, Chairperson
Estelle D. Kurtz, Member
Judith A. Erlen, Member

Date: 12/4/81

_____ Dean, College of Nursing

Date: _____

BVW/smu
10/14/81

APPENDIX B

TWU Texas Woman's University
P.O. Box 22479, Denton, Texas 76204 (817) 383-2302, Metro 434-1757, Tex-An 834-2133
THE GRADUATE SCHOOL

January 13, 1982

Ms. Michele Carter

Dear Ms. Carter:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Robert S. Pawlowski
Provost

dl

cc Dr. Helen Bush
Dr. Anne Gudmundsen

APPENDIX C

March 29, 1982

Dear Oncology Nursing Society Member:

I am presently conducting a study to determine the relationship of the values of nurses and their perceptions of responsibility in ethical dilemmas. Oncology nurses are frequently involved in clinical situations which involve difficult personal and professional decisions. The data collected from this survey will provide insight and clarification of the existing conflicts experienced by clinical oncology nurses.

Consideration of what we value and how we perceive responsibility often produces thought-provoking questions. Awareness of your unique thoughts about these issues is the basis for the collection of the requested data. Your participation in this study involves the completion of two questionnaires and a subject profile; the total time necessary to complete these forms ranges between 30-45 minutes. The instructions appear on the introductory page of each questionnaire.

My request is for you to take some time to answer the questions and for you to return the completed forms by May 1, 1982. A self-addressed, stamped envelope is provided in your packet for your convenience. Please know that all of your responses will be treated confidentially. COMPLETION AND RETURN OF THE ENCLOSED QUESTIONNAIRES WILL SIGNIFY YOUR INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

To further protect your privacy, please do not put your name on either of the questionnaires.

Thank you for your time and for the presentation of your thoughts on these important matters.

Sincerely,

Michele Carter, R.N., B.S.

P.S. If you would be interested in receiving an abstract of the findings of this research study, please indicate on the form attached. To protect your anonymity, do not include this request with the completed questionnaires, but mail in a separate envelope. Thank you.

APPENDIX D

Allport-Vernon-Lindzey Study of Values:
A Scale for Measuring the Dominant
Interests in Personality

A copy of this instrument may be obtained from:

Houghton-Mifflin Publishing Co.
Boston, Massachusetts

APPENDIX E

The Nursing Dilemma Test

A copy of this instrument may be obtained from:

Patricia Crisham, Ph.D., R.N.
Assistant Professor
School of Nursing
University of Minnesota
5-140 Unit F
308 Harvard Street
Minneapolis, Minnesota 55455
Phone: 612/373-3462

APPENDIX F

UNIVERSITY OF MINNESOTA
TWIN CITIES

School of Nursing
5-140 Unit F
308 Harvard Street
Minneapolis, Minnesota 55455
(612) 373-3462

October 1, 1981

Michele Carter, B.S., R.N.

Dear Ms. Carter:

Thank you for your comments about the Nursing Dilemma Test. One of the benefits of that Nursing Research article is the opportunity to come to know others who share a similar research interest. I am happy to share the Nursing Dilemma Test--you use it with my permission. My request is that you send a summary of your findings so that we may continue to gather data on the Test.

As you know from the March-April Nursing Research article, there are three Nursing Dilemma scores you may want to use: Nursing Principled Thinking (NP); Pratical Considerations (PC); Familiarity (F). In the NDT rankings, the item ranked as most important with each dilemma was given 6 points, the item ranked second was given 5 points, the item ranked third was given 4 points, the item ranked fourth was given 3 points, the item ranked fifth was given 2 points, and the item ranked sixth was given 1 point. The NP score was calculated by adding the scores of the NP items across the six dilemmas. The NP index represents the sum of weighted ranks given to principled items and is interpreted as the relative importance given to Principled moral considerations in making a nursing moral decision. The highest possible NP score is 66 with 2 NP items for each dilemma.

The relative importance given to practical considerations was indexed in a smiliar process. The PC score was calculated by adding the scores of items that represented Practical Considerations across the six dilemmas. The PC index represents the sum of weighted ranks given to Practical Considerations and is interpreted as the relative importance given to Practical Considerations in making a nursing moral decision. The highest possible PC score is 36 with 1 PC item for each dilemma.

You may be interested in obtaining a similar score for Stage 2, Stage 3, or Stage 4 thinking. You may also be interested in examining the subject's action choice in Part A of the Test.

To measure the subject's degree of previous involvement with a similar dilemma, a Likert-type scale was used with each dilemma. On this five-point scale, "1" indicated, "Made a decision in a similar dilemma"; "2" indicated "Knew someone else in a similar dilemma"; "3" indicated, "Not known anyone in a similar dilemma but dilemma is conceivable"; "4" indicated, "Difficult to imagine the dilemma as it seems remote"; and "5" indicated, "Difficult to take the dilemma seriously as it seems unreal." The Familiarity (F) score was calculated by adding the points that indicated the subject's degree of previous involvement with similar dilemmas across the six dilemmas. The F index represents the sum of the subject's indication of degree of involvement with similar dilemmas. The classification of the subject as familiar or unfamiliar with the dilemmas was based on the properties of the F scale; a score of 6 through 17 indicated familiar with the dilemmas, and a score of 18 through 30 indicated unfamiliar with dilemmas.

With the enclosed Test and Key, my hope is that you have the information you need. My Ph.D. Thesis, "Moral Judgment of Nurses in Hypothetical and Nursing Dilemmas," University of Minnesota, August 1979, may also be of help.

My best wishes to you in your research and work in this important area of ethical issues in nursing.

Sincerely,

Patricia Crisham

Patricia Crisham, R.N., Ph.D.
Assistant Professor

PC:th

Enclosure

APPENDIX G

COMPLETION AND RETURN OF THIS INSTRUMENT WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY

Subject Profile

Instructions: Please fill in the blanks with a ✓ or number. Thank you.

Age in years:

_____

Sex:

_____ Male

_____ Female

Marital Status:

_____ Single

_____ Married

_____ Widowed

_____ Divorced

Highest Educational Level:

_____ Diploma

_____ Associate degree

_____ Baccalaureate degree

_____ Master's degree

_____ Doctoral degree

Number of years in Nursing Practice:

_____

Preferred Religious Affiliation:

_____

Importance placed on preferred religious affiliation:

_____ little

_____ moderate

_____ high

APPENDIX H

STUDY OF VALUES

INTERPRETATION

College Males

High and low scores. A score on one of the values may be considered definitely high or low if it falls outside the following limits. Such scores exceed the range of 50% of all male scores on that value.

Theoretical	39-49	Social	32-42
Economic	37-48	Political	38-47
Aesthetic	29-41	Religious	32-44

Outstandingly high and low scores. A score on one of the values may be considered very distinctive if it is higher or lower than the following limits. Such scores fall outside the range of 82% of all male scores.

Theoretical	34-54	Social	28-47
Economic	32-53	Political	34-52
Aesthetic	24-47	Religious	26-51

College Females

High and low scores. A score on one of the values may be considered definitely high or low if it falls outside the following limits. Such scores exceed the range of 50% of all female scores on that value.

Theoretical	31-41	Social	37-47
Economic	33-43	Political	34-42
Aesthetic	37-48	Religious	37-50

Outstandingly high and low scores. A score on one of the values may be considered very distinctive if it is higher than the following limits. Such scores fall outside the range of 82% of all female scores for that value.

Theoretical	26-45	Social	33-51
Economic	28-48	Political	29-46
Aesthetic	31-54	Religious	31-56

APPENDIX I

NURSING DILEMMA TEST KEY

Dilemma	Rankings Part B	
	Item	Code
1	1	2
	2	PC
	3	NP
	4	4
	5	3
	6	NP
2	1	3
	2	2
	3	NP
	4	PC
	5	4
	6	NP
3	1	2
	2	4
	3	NP
	4	PC
	5	3
	6	NP
4	1	4
	2	3
	3	PC
	4	2
	5	NP
	6	NP
5	1	2
	2	NP
	3	PC
	4	NP
	5	3
	6	4
6	1	4
	2	PC
	3	3
	4	NP

Dilemma	Rankings Part B	
	Item	Code
	5	2
	6	NP

REFERENCE NOTES

1. Crisham, P. Personal communication, October 1, 1981.

REFERENCES CITED

Allport, G. W. Becoming basic considerations for a psychology of personality. New Haven: Yale University Press, Inc., 1955.

Allport. G. W. Normative compatibility in the light of social science. In A. Maslow (Ed.), New knowledge in human values. New York: Harper and Row, 1959.

Allport, G. W. Pattern and growth in personality. New York: Holt, Rinehart, and Winston, 1961.

Allport, G. W., Vernon, P. E., & Lindzey, G. Manual study of values (3rd ed.). Boston: Houghton-Mifflin Co., 1970.

Aroskar, M. A. Ethics in the nursing curriculum. Nursing Outlook, 1977, 25, 260-264.

Bandman, A. Why ethics in nursing practice? Imprint, December 1979, pp. 34-62.

Brand, V. R. Graduates of a basic baccalaureate program and of a baccalaureate program for registered nurses compared. Nursing Research, 1967, 16(4), 347-351.

Buros, O. K. (Ed.). The eighth mental measurements yearbook (Vol. 1). Highland Park, N.J.: Gryphon Press, 1978.

Bush, H. A., & Alford, D. M. Standards of nursing practice and documentation of nursing care. In A. C. Robbins (Ed.), Medical surgical nursing of the ill or injured adult. New York: John Wiley and Sons, Inc., in press.

Crisham, P. Nursing dilemma test. Minneapolis, Minn.: University of Minnesota, 1978.

Crisham, P. Measuring moral judgment in nursing dilemmas. Nursing Research, 1981, 30(2), 104-110.

Curtin, L. L. Nursing ethics: Theories and pragmatics. Nursing Forum, 1978, 17, 4-11.

Curtin, L. L. The nurse as advocate: A philosophical foundation for nursing. Advances in Nursing Science, 1979, 1(3), 1-10.

Davis, A. J., & Aroskar, M. A. Ethical dilemmas and nursing practice. New York: Appleton-Century-Crofts, 1978.

Dewey, J. Moral principles in education. Carbondale: Southern Illinois University Press, 1909.

Dickoff, J., & James, P. Beliefs and values: Bases for curriculum designs. Nursing Research, 1970, 19(5), 415-426.

Dustan, L. C. Characteristics of students in three types of nursing education programs. Nursing Research, 1964, 13(2), 159-166.

Fenner, K. M. Ethics and law in nursing: Professional perspectives. New York: D. Van Nostrand Co., 1980.

Fromer, M. J. Ethical issues in health care. St. Louis, Mo.: The C. V. Mosby Co., 1981.

Gadow, S. Introduction. In S. F. Spicker & S. Gadow (Eds.), Nursing: Images and ideals opening dialogue with the humanities. New York: Springer Publishing Co., 1980.

Garvin, B. I. Values of male nursing students. Nursing Research, 1976, 25(5), 352-357.

Gortner, S. R. Nursing major in twelve Western universities: A comparison of registered nurse students and basic senior students. Nursing Research, 1968, 17(2), 121-129.

Hall, C. S., & Lindzey, G. Theories of personality (2nd ed.). New York: John Wiley and Sons, Inc., 1970.

Hall, C. S., & Davis, J. Moral education in theory and practice. Buffalo, N.Y.: Prometheus Books, 1975.

Ketefian, S. Critical thinking, educational preparation, and development of moral judgment among selected groups of practicing nurses. Nursing Research, 1981, 30(2), 98-103.

Kohlberg, L. Stage and sequence: The cognitive-developmental approach to socialization. In A. Goslin (Ed), Handbook of socialization theory and research. Chicago: Rand-McNally Co., 1969.

Kohlberg, L. A cognitive-development approach to moral education. The Humanist, 1972, 38, 13-16.

Kohlberg, L. Continuities in childhood and adult moral development revisited. In P. Baltes & K. Share (Eds.), Life-span development psychology: Personality and socialization. New York: Academic Press, 1973. (a)

Kohlberg, L. The claim to moral adequacy of a highest stage of moral judgment. Journal of Philosophy, 1973, 70(18), 631-632. (b)

Kohlberg, L., & Turiel, E. Moral development and moral education. In G. Lesser (Ed.), Psychology and educational practice. Chicago: Scott and Foresman, 1971.

Levine, M. E. Nursing ethics and the ethical nurse. American Journal of Nursing, 1977, 77(5), 845-849.

Mahon, K. A., & Fowler, M. D. Moral development and clinical decision-making. Nursing Clinics of North America, 1979, 14(1), 3-12.

Maslow, A. H. Preface. In A. H. Maslow (Ed.), New knowledge in human values. New York: Harper and Row, 1959.

May, W. T., & Ilardi, R. L. Change and stability of values in collegiate nursing students. Nursing Research, 1970, 19(5), 359-362.

Munhall, P. L. Moral reasoning levels of nursing students and faculty in a baccalaureate nursing program. Unpublished doctoral dissertation, Columbia University Teachers College, 1979.

Murphy, C. P. Levels of moral reasoning in a selected group of nursing practitioners. Unpublished doctoral dissertation, Columbia University Teachers College, 1976.

Neff, R. Accountability for educational results. In W. Hastrop, J. Mecklenberger, & J. Wilson (Eds.), Accountability for education. Hamden, Connecticut: Linnet Books, 1973.

Oncology Nursing Forum. Annual publication, 1981. Pittsburg, Pa.: Author, 1981.

O'Neill, M. F. A study of baccalaureate nursing student values. Nursing Research, 1973, 22(4), 437-443.

Peplau, N. Responsibility, authority, evaluation, and accountability of nursing in patient care. Michigan Nurse, 1971, 44(5-8), 20-23.

Piaget, J. The moral judgment of the child. New York: Harcourt, Brace, & Co., 1932.

Polit, D., & Hungler, B. Nursing research: Principles and methods. Philadelphia: J. B. Lippincott Co., 1978.

Redman, B. K. Predominant values of selected intermediate nursing students and their clinical teachers. Nursing Research, 1966, 15, 348-350.

Rest, J. R. Manual for the defining issues test: An objective test of moral judgment. Minneapolis: University of Minnesota, 1974.

Rest, J. R. Development in judging moral issues. Minneapolis: University of Minnesota, 1979.

Robinson, J. R., & Shaver, P. R. Measures of social psychological attitudes (revised ed.). Ann Arbor: University of Michigan, 1973.

Rokeach, M. The nature of human values. New York: The Free Press, 1973.

Schoenrock, N. B. An analysis of moral reasoning levels and the implications for the nursing curriculum. Unpublished doctoral dissertation, University of Texas at Austin, 1978.

Shirk, E. The ethical dimension: An approach to the philosophy of values and valuing. New York: Appleton-Century-Crofts, 1965.

Sigman, P. Ethical choice in nursing. Advances in Nursing Science, 1979, 1(3), 37-52.

Smith, J. Personality structure in beginning nursing students: A factor-analytic study. Nursing Research, 1968, 17(2), 140-145.

Watson, J. Nursing: The philosophy and science of caring. Boston: Little, Brown, and Co., 1979.

Williams, R. M. American society: A sociological interpretation (2nd ed.). New York: Alfred A. Knopp, 1960.

Wilson, H. A case for humanities in professional nursing education. Nursing Forum, 1974, 13(4), 406-416.