RESEARCH

DEVELOPING NURSES' MORAL REASONING SKILLS

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ABSTRACT

Analysis of data from a Nursing Dilemma Test administered to 69 registered nurses employed at the Groote Schuur Hospital in Cape Town revealed a pattern of principled thinking in the groups with 5 to 9, 20 to 24, 25 to 29 and 30 to 34 years of clinical experience, whereas the group with the least clinical experience (0 to 4 years) showed no distinguishable pattern of thinking stages in moral judgement development.

SAMEVATTING

Data analise van n Verpleging Konflik Toets, afgele deur 69 geregistreerde verpleegkundiges in diens van Groote Schuur Hospitaal in Kaapstad, toon n patroon van beginselvaste denke in the groepe met 5-9, 20-24, 25-29 en 30-34 jaar kliniese ondervinding, in vergelyking met die groep met die minste kliniese ondervinding (0 tot 4 jaar) wat geen uitstaande denk patroon toon ten opsigte van morele oordeels ontwikkeling nie.

INTRODUCTION

How do nurses learn moral reasoning skills? How is moral reasoning measured? An attempt was made to answer these questions from data collected at a series of 1-day nursing ethics workshops for registered nurses at Groote Schuur Hospital in Cape Town. The assumption was that *"The personal value structure of the nurse and its impact on decision making in nursing remain vague and neglected. Little in nursing education prepares nurses to perceive moral issues that arise in practice or to make decisions in situations in which they must exercise moral judgment skills. In nursing situations that have no apparent clear-cut right or wrong solutions, nurses face typical moral dilemmas, that is, problems with two equally unacceptable alternatives. Nurses, therefore, regularly grapple with moral decisions"* (Crisham 1981:105).

Problem statement

Registered nurses (RNs) in South Africa receive inadequate instruction in moral decision making and have to depend on intuition.

Purpose of the study

The purpose of this study was to measure RNs stage of thinking in moral judgement development.

Research design

A quantitative descriptive study.

Ethical considerations

Study subjects were given a code number and were told that only the investigator would have access to both the names and code numbers, in this way ensuring anonymity and confidentiality. The study was approved by the Groote Schuur Hospital Nursing Division Ethics Committee.

METHODOLOGY

Data were collected by the investigator by administering a Nursing Dilemma Test (Crisham 1981:107) (Appendix 1) to each study subject at a nursing ethics workshop.

Background to the ethics workshops:

Attendance at the ethics workshops was voluntary and after an informal "getting to know you" session over coffee, participants were given a code number for purposes of confidentiality in the event of future correspondence with the writer because of the sensitive nature of certain ethical issues. Analysis of the participants' expectations clearly indicated that there were serious knowledge deficits regarding nursing ethics and the programme was adjusted accordingly to meet learning needs. Participants were asked to complete a Nursing Dilemma Test (NDT) at the start of the workshop so that results would not be influenced with new knowledge gained during the workshop.

Reconceptualization and clarification of ethical concepts such as values, codes of conduct, ethical principles and theories was achieved by group discussion. Smith & Davis (1985:337) list the following tasks for nursing ethics: *"(1) to assist nurses to develop the ability to integrate ethical reasoning into their practice and to use this ability to reflect upon bioethical issues, (2) to identify the role of nursing and nurses in any public debate on bioethical issues, (3) to identify the role of nurses in providing input and participation in ethical decision-making about particular clients, and (4) to develop monitoring and reporting mechanisms in order to ensure that persons act ethically toward the client"*. Similarly, Davis & Aroskar (1983:4) maintain that the task in health care ethics is *"neither to discover some new moral principles on which to build a theoretical ethical system nor to evolve new approaches to ethical reasoning, but to prepare the ground for the application of the established general moral rules"* and to sensitise health professionals to ethical issues in health care.

At the workshops the ethical principles of autonomy, confidentiality, beneficence, nonmaleficence, justice and veracity served as a basis for small group discussions of realistic nursing dilemmas selected from the literature. Mitchell (1981:33-5) suggests the following benefits in using case studies in bioethics courses: 1) sensitizing the student to the importance of analysing the data in each case; 2) alerting the student to the value of a carefully constructed methodology and applying it to a particular case; 3) providing the opportunity for different philosophical and theological perspectives to be heard; 4) allowing students to test different theoretical approaches to decision-making; 5) alerting students to the many conflicting rights in specific cases; 6) emphasising the importance of different parties participating in the decision-making process; 7) revealing the role of creative imagination in the decision-making process; as well as an appreciation of 8) the significant intellectual and personal energy investments that are required in the decision-making process.

In the current climate of increased awareness of legal rights and medical lawsuits in SA,

there is a growing tendency by the nursing profession to emphasize the legal consequences of nursing actions at the expense of ethical considerations resulting in a legal-moral tension in nursing (Johnstone 1988:149). Evidence of professional discipline can be found in well entrenched control structures formalised in legislation such as the Disciplinary Committee of the South African Nursing Council (The Nursing Act, No 50 of 1978) as well as in hospital-based disciplinary committees (Du Preez 1988:19).

On the other hand ethical control of professional conduct by members of the profession, although described in SA nursing literature as an essential characteristic of a profession (Mellish 1988:71), has not had the same treatment. The South African Nursing Association (SANA) has attempted to achieve this at a national level and certain hospitals have established nursing ethics committees (Du Preez 1988:17). There is no SA nurses' code of conduct such as the United Kingdom Central Council Code of Professional Conduct (Pyne 1987: 510) intended to improve standards of conduct. Instead, the Florence Nightingale Pledge of Service and later the SANA Pledge of Service have attempted to meet this need, but these pledges are limited in scope and therefore provide inadequate ethical guidance for nursing standards in SA in the 90s where trade unionism is threatening to replace professionalism and where an ethical tension exists between the obligation to benefit the individual client and the obligation to benefit society (Fry 1985:303). A solution to the legal-moral tension offered by Milner (1993:25) suggests that *"Nurses do not need to be guided by rules; nurses can be guided by principles"*.

Before concluding the workshops participants were given guidance on how to do an ethical assessment of a patient based on the ICN Code for Nurses and a Patient's Bill of Rights (Woodruff 1985:300). This has produced interesting results but these will not be discussed here. Finally, analysis of the data collected during the nine workshops indicated that a useful retrospective study was emerging.

Data collection tool

The NDT (Crisham 1981:107) measures moral judgement in real-life nursing dilemmas as opposed to the DIT (Defining Issues Test) that measures moral judgement in hypothetical general dilemmas (Crisham 1981:105) and for this reason the NDT was considered more appropriate. Furthermore the NDT measures the importance given to moral and practical considerations in the complex decision-making process (Crisham 1981:106) and is based on cognitive theory of moral development (Kohlberg 1969; Piaget 1965 cited in Crisham 1981:107) which is well documented (Frisch 1987; Parker 1990; Parker 1990; Callery 1990; Felton & Parsons 1987). The structure of the NDT was specifically influenced by Rest's research and stage definitions of moral judgement behaviour (1979 cited in Crisham 1981:107). The relationship of participants' length of clinical nursing experience and familiarity with the dilemma to moral reasoning skills was determined, but, although *"Educational level has been documented as the most powerful correlate of moral judgment development"* (Crisham 1981:108) it was not the focus of the present study.

The question "What should the nurse do?" (Appendix 1) focusses on the inherent conflict in the dilemma. The 6 items that have to be ranked in order of importance include major moral and practical considerations pertaining to the dilemma, and the final section deals with the degree of familiarity with the dilemma on a Likert-type scale.

Study sample

Of the 109 registered nurses who attended the workshops, only 69 had provided information about the length of their clinical nursing experience so this became the study sample which included only one (1) male. Although there were spoilt questions in each section, this did not exclude participants. No distinction was made between those who held a degree or a diploma in nursing.

Data analysis

Unlike Crisham's study (1981) in which data for each study subject was analysed across six NDT allowing for sophisticated statistical analysis, in the present study only one NDT was applied because only one was available in accessible literature. Thus only frequency distribution tables were used to analyse data. Furthermore, in the present study Rest's stages of thinking (1979 cited in Crisham 1981:107) may not have been interpreted as in Crisham's study, but consistency of application, albeit subjective, was checked by a clinical nurse expert with 28 years of experience.

RESULTS AND DISCUSSION

"What should the nurse do?"

In response to the question "What should the nurse do?" (Appendix 1) data in Table 1 below indicate that the majority of participants (59,4%), irrespective of length of clinical experience (Table 2), felt that the patient's questions should be answered *("the patient has the right to know; yes, as his advocate")* Clearly, these participants argued in favour of the patient's right to information, thus defending the ethical principle of autonomy over the principle of confidentiality. However, of these participants, some qualified their decision with statements such as *"assess patient's emotional, mental state and coping skills; discuss with doctor; depending on circumstances"* indicating some uncertainty in moral decision-making. It is not clear what may have contributed to this uncertainty, but the participants may possibly have been concerned about the effect that the information may have on the patient. This implies conflict between upholding the ethical principle of beneficence vis-a-vis nonmaleficence, and it also implies an utilitarian approach to moral decision-making which considers consequences.

Table 1. Frequency of scores in response to the question "What should the nurse do?"

N=69		Frequency
1.	Should answer the patient's questions	41 (59,4%)
2.	Can't decide	14 (20,3%)
3.	Should not answer the patient's questions	10 (14,5%)
	Spoilt	4 (5,8%)

Length of clinical experience

When grouped by length of clinical experience (Table 2) most of the study subjects (n=15; 21,6%) were found to have between 20 and 24 years of experience. Of note is the finding that of those who could not decide what to do, five participants had between 20 and 24 years of clinical nursing experience, and two had respectively between 25 and 29 years of experience and 30 and 34 years of experience. Four participants had not completed this section, three of whom had between 5 and 9 years of experience, resulting in spoilt questions. This could mean that these participants could not decide what do do, thus bringing the total number of participants for this category to eighteen (26,1%). This ambivalence could be attributed to the fact that these nurses, albeit very experienced, have not received instruction in moral decision-making or the ambivalence may be explained by Lyth's (1990:449) interpretation of the management of anxiety within a hospital as "Delegation in the hospital seemed to move in a direction opposite to the usual one. Tasks were frequently forced upwards in the hierarchy so that all responsibility for their performance could be disclaimed". Alternatively, they may have learnt from vast experience to view such ethical situations with caution until all the facts are known.

Those participants who indicated that the nurse should not answer the patient's questions, of whom the majority had more than 15 years of experience, qualified their decision with statements that reflect two ethical approaches to moral decision-making. The deontological (duty) perspective is evident in phrases such as *"doctor's duty - afterwards answer questions; refer to doctor"*

Table 2. Frequency of scores by length of clinical nursing experience in response to the question "What should the nurse do?".

N = 69	Years of experience						
	0-4	5-9	10-14	15-19	20-24	25-29	30-34
	n=3	n=11	n=9	n=11	n=15	n=12	n=8
Should answer	2	4	7	7	8	9	4
Can't decide	1	3		1	5	2	2
Should not answer		1	2	3	1	1	2
Spoilt	3				1		

implying that there is a duty towards the doctor as the team leader to make the decision. Utilitarianism is indicated in phrases such as *"look at circumstances surrounding; should not leave the matter there - liaise with doctor and family about how to tell the patient about his diagnosis"* which imply a consideration of the consequences of answering the patient's questions. However, without qualitative data which an interview with each of the participants would have provided, it is difficult to make more sense of the participants' level of moral reasoning.

Stage of thinking in moral judgement development

Data in Table 3 indicate frequency of scoring of the 6 ranked items on the NDT (Appendix 1) requiring application of moral and practical considerations pertinent to the dilemma. Each of the items reflect a stage of thinking in moral judgement development. The ranking order indicates perceived importance of the items, which, in turn, reflects the participants' stage of thinking in moral judgement development. The frequency score of the ranked items indicate that Item 6 *"Does the patient in his own case have the right to decide about who should know the diagnosis"*, which in the present study reflects principled thinking (Stage 5 and 6 thinking), was regarded by the majority (62,3%) of study subjects as the most important consideration in the dilemma. *"A nurse who reasons at a morally-principled level is more likely to make nursing decisions supportive of the rights of others"* (Felton & Parsons 1987: 7). Clearly, the ethical principle of autonomy for the individual is regarded as the most important consideration for the purposes of the present study. Furthermore, the results suggest that nurses do not need to be guided by rules but that they can be guided by principles (Milner, 1993).

Item 1 *"How can I best follow the specifications on sharing information in the patient's Bill of Rights?"* reflects Stage 4 thinking in the present study because it reflects protection of morality by a Bill of Rights, and this was selected as the second most important consideration (42%). For the purposes of the present study, a practical consideration (Item 2) *"Is the physician on the unit during times when it would be possible to discuss this?"* was ranked as the third most important consideration. Item 3 *"Are the wishes of the patient's family most important because the family is closest to the patient?"* reflects Stage 2 thinking in the present study because it implies the possibility of negotiation and was selected as both the fourth and fifth most important considerations. The least important consideration (53,6%) selected was Item 5 *"Could the family and the physician do anything to me for answering the patient's questions?"*, which, in the present study, reflects Stage 1 thinking because it reflects the morality of obedience. Data in Table 4 indicate that the group with 5 to 9 years of experience is the most representative of the level of moral judgement development of the sample (Table 3).

Relationship of stage of thinking in moral judgement development to length of clinical nursing experience and familiarity with dilemma

In the present study the sample of registered nurses (N=69) showed a pattern of principled thinking by ranking items in order of importance, featuring a satisfactory level of moral judgement development (Table 4). Moral judgement development has been interpreted in terms of the placement of items reflecting principled thinking (Stages Five and Six) as the most important consideration in the dilemma. Stage One is the least important consideration and hence the least ideal stage of moral judgement development. The meaning of the order of the other thinking stages is difficult to interpret without more sophisticated statistical analysis. Nevertheless, satisfactory stages of thinking and hence moral judgement development were found in the groups with 5 to 9, 20 to 24, 25 to 29 and 30 to 34 years of experience. Interestingly, those study subjects with 10 to 14 and 15 to 19 years of experience were found to have evidence of Stage One thinking at an inappropriate level of moral reasoning (Table 4), whereas the emergence of no distinguishable pattern of thinking stages in moral judgement development within the group that had the least experience, was not surprising. It may be that *"Planning of nursing education curricula and staff development programs depends on presently assumed, but untested, knowledge about nurses' ethical decision making"* (Crisham 1981:105). Furthermore, it raises serious questions such as *"Do nursing programs foster the moral reasoning necessary for nurses to make principled decisions?"* (Felton & Parsons 1987:7).

TABLE 3. Frequency scores of ranked items indicating stage of thinking in moral judgement development

N = 69

Items	Most important	Second most important	Third most important	Fourth most important	Fifth most Important	Sixth most Important
6	43 (62,3%) [NP]	13 (18,8%)	3 (4,3%)	1 (1,4%)	4 (5,8%)	0
5	2 (2,9%)	1 (1,4%)	2 (2,9%)	10 (14,5%)	11 (15,9)	37(53,6%)[S1]
4	0	7 (10,1%)	17 (24,6%)	16 (23,2%)	16 (23,2%)	7 (10,1)
3	1 (1,4%)	4 (5,8%)	10 (14,5%)	17 (24,6%) [S2]	21(30,4%)[S2]	9 (13%)
2	0	9 (13%)	20 (28,9%) [PC]	16 (23,2%)	9 (13%)	9 (13%)
1	17 (24,6%)	29 (42%) [S4]	11 (15,9%)	3 (4,3%)	2 (2,9%)	1 (1,4%)
Spoilt	6 (8,7%)	6 (8,7%)	6 (8,7%)	6 (8,7%)	6 (8,7%)	6 (8,7%)

LEGEND:

Item 6 = Nursing principled thinking (NP) representing Stage 5: The morality of societal consensus: "What laws the people want to make are what ought to be" and Stage 6: The morality of nonarbitrary social cooperation: "How rational and impartial people would organize cooperation is moral."

Item 5 = Stage one thinking (S1): The morality of obedience: "Do what you're told."

Item 4 = Stage three thinking (S3): The morality of personal concordance: "Be considerate, nice, and kind, and you'll get along with people.

Item 3 = Stage two thinking (S2): The morality of instrumental egoism and simple exchange: "Let's make a deal."

Item 2 = Practical considerations (PC).

Item 1 = Stage four thinking (S4): The morality of law and duty to the social order: "Everyone in society is obligated and protected by the law".

(Rest 1979 cited in Crisham 1981:107)

In the present study the degree of familiarity with the dilemma was indicated on a Likert-type scale on the NDT (Appendix 1). A scoring of 1-2 *(1 = "Made a decision in a similar dilemma; 2 = Knew someone else in a similar dilemma"*) was accepted as being familiar with the dilemma, whereas a scoring of 3-5 *(3 = "Not known anyone in a similar dilemma, but dilemma is conceivable; 4 = Difficult to imagine the dilemma as it seems remote; 5 = Difficult to take the dilemma seriously as it seems unreal")* indicated unfamiliarity with the dilemma. Spoilt questions were regarded as indicating unfamiliarity with the dilemma. The degree of familiarity with the dilemma is indicated in a frequency distribution table (Table 4).

The group with 0 to 4 years of experience was the least familiar with the dilemma, while the group with 25 to 29 years of experience was the most familiar (75%). An unexpected finding is that the group with 15 to 19 years of experience showed only 36,4% familiarity with the dilemma and the group with 30 to 34 years of experience showed only 37,5% familiarity with the dilemma. This is particularly interesting because previous involvement with the dilemma is assumed to enhance principled thinking (Crisham 1981:110). Data for these two groups suggest principled thinking although strongly suggestive of a practical approach to moral decision-making for the group with 30 to 43 years of experience, while data for the group with 0 to 4 years of experience reflect unfamiliarity with the dilemma as well as no clear pattern of judgement development.

CONCLUSION

The inconclusive findings of the present study confirm the assumption that little is known about the impact of the personal value structure of the nurse on decision-making (Crisham 1981:105) and that the values held by nurses need to be explored if nursing principled thinking is to be enhanced. Furthermore, the application of cognitive theory to explain moral development may be too limited, and the phenomenological tradition should be explored to provide a deeper understanding of moral development.

The ethics workshops provided a much needed opportunity to reflect upon bioethical issues and to review the role of nurses and nursing in bioethical debates, but more particularly, to sensitise the participating nurses to ethical issues in health care (Davis & Aroskar, 1983). Evaluation of the workshops revealed that the case study discussions, through the process of coaching, had provided an opportunity for participants to clarify their values, to practice ethical reasoning, applying new ethics terminology with confidence and to gain deeper understanding of moral issues in nursing practice. Participants also suggested that all categories of nurses would benefit from attending the workshops thus confirming the value of bioethics case studies (Mitchell 1981) for teaching ethics. From the discussions, it appears that there is now, in the history of nursing in SA, an urgent need for a code of conduct to guide moral standards which addresses not only responsibility to patients or clients, but also responsibility for professional standards by maintaining knowledge and skills, responsibility to colleagues and professional and personal responsibility. Unless personal responsibility is accepted at all levels of the hierarchy of a health care service, there can be no perceived moral obligation to make principled decisions.

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TABLE 4. Relationship of stage of thinking in moral judgement development to length of clinical nursing experience and familiarity with dilemma

N = 69

Years of experience	most important	Second most important	Third most important	fourth most important	fifth most important	sixth most important	familarity with dilemma
0-4 yrs n = 3	NP, S1, S4	NP, PC, S4	NP, S2, S4	S3	S1, S2, PC	S1, S3, S2	0/3
*5-9 yrs n = 11	NP	S4	PC	S2	S3	S1	5/11 (45,5%)
10-14 yrs n = 9	NP	S4	S2, PC	S1, S3, S2, PC	S3, S2	S1	5/9 (55,5%)
15-19 yrs n = 11	NP	S4	S3, PC	S1, PC	S2	S1	4/11 (36,4%)
20-24 yrs n = 15	NP	S4	S3	S2	S2	S1	8/15 (53,5%)
25-29 yrs n = 12	NP	S4	PC	S3, PC	S3	S1	9/12 (75%)
30-34 yrs n = 8	NP	PC	S4	S3, S2, PC	S3	S1	3/8 (37,5%)

* Group most representative of the ranked frequency scores of the total sample in Table 3 also reflecting a high level of moral judgement meaningfully associated with familiarity with the nursing dilemma (9/12) which enhances principled thinking.

Legend:

NP =	Nursing principled thinking (representing Stage 5: The morality of societal consensus: "What laws the people want to make are what ought to be" and Stage 6: The morality of nonarbitrary social cooperation: "How rational and impartial people would organize cooperation is moral.")
S1 =	Stage one: The morality of obedience: "Do what you're told."
S2 =	Stage two: The morality of instrumental egoism and simple exchange: "Let's make a deal."
S3 =	Stage three: The morality of personal concordance: "Be considerate, nice, and kind, and you'll get along with people.
S4 =	Stage four: The morality of law and duty to the social order: "Everyone in society is obligated and protected by the law".
PC =	Practical considerations

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APPENDIX 1

Please indicate: Number of yearsof parttime or fulltime nursing experience:

Example of Terminally Ill Adult Dilemma in the Nursing Dilemma Test

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

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

Should answer the patient's questions _____

Can't decide _____

Should not answer the patient's questions _____

B. The nurse considers the following six issues:

1. How can I best follow the specifications on sharing information in the patient's Bill of Rights?
2. Is the physician on the unit during times when it would be possible to discuss this?
3. Are the wishes of the patient's family most important because the family is closest to the patient?
4. Would I be meeting the fair expectations of the patient and his family?
5. Could the family and the physician do anything to me for answering the patient's questions?
6. Does the patient in his own case have the right to decide about who should know the diagnosis?

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

Most Important _____ Fourth Most Important _____

Second Most Important _____ Fifth Most Important _____

Third Most Important _____ Sixth Most Important _____

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

1 = Made a decision in a similar dilemma.

2 = Knew someone else in a similar dilemma.

3 = Not known anyone in a similar dilemma, but dilemma is conceivable.

4 = Difficult to imagine the dilemma as it seems remote.

5 = Difficult to take the dilemma seriously as it seems unreal.

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

Source: Crisham P. Measuring moral judgment in nursing dilemmas. Nurs Res March-Apr 1981:30(2):107.