Effect of Adding Alternative Methods of Ethics Instruction
to Baccalaureate Nursing Programs

by

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Thesis

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Abstract

The purpose of this study was to determine whether additional focused ethical case studies and a roundtable discussion would increase baccalaureate nursing students' moral competency over the traditional methods of nursing ethics education alone. The study used an experimental design in which 18 senior nursing students completed the Moral Competency Test (MCT) before and after the presentation of ethical case studies and a roundtable discussion. Data analysis was performed using the Mann-Whitney U-test. Results of the U-test indicated no statistically significant difference in the scores between the experimental and control groups (U = 36.00, p = .690). Nevertheless, as a pilot study, the theoretical framework remains promising. The MCT potentiates the evaluation of ethics education in nursing programs over time. Future studies could improve research by recruiting several universities, offering methods to better engage student participants, and measuring moral competency longitudinally from student admission to graduation.
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Chapter I

Introduction

Background and Significance of the Problem

From the good spirit within one’s soul to the social contract between citizens, philosophers have tried to map the nature of what it means to be good in our thoughts, actions and words. Ethics is a main branch of philosophy that involves the study of morality. In accordance with philosophical tradition, it is appropriate to clearly identify and define the portion of ethics focused on within this thesis (Cooper & Hutchinson, 1997). A distinction between ethics and morality is often blurred using religious principles or other philosophical terms (Doris & Stich, 2014). Interestingly, *The Cambridge Dictionary of Philosophy* (CDP) (Audi, 1995) recognizes that ethics and morality are often used synonymously, but it does not offer a separate definition of morality. As an alternative, CDP posits that morality is a sub-discipline of ethics that, at times, “is used more narrowly to mean the moral principles of a particular tradition, group, or individual” (Audi, 1995, p. 244). The way we think, learn, and even theorize about morality is as significant as how we perform morally in certain situations (Nadelhoffer, Nahmias, & Nichols, 2010). Ethics, then, needs help from another field, such as psychology, to explain some of the underpinnings of moral behavior. In fact, the specialties of psychology and philosophy of mind overlap as the discipline now known as moral psychology (Doris & Stich, 2014). Ethics in the context of nursing is complex and requires a multidimensional education for nursing students. In other words, no single discipline or theory can effectively guide nursing ethics education. Traditional approaches to teaching ethics do lay the groundwork; however, broader and more
comprehensive methods are essential for new nurses to gain competency in today’s complex healthcare environment.

Moral psychology helps us to understand the different frameworks from which ethics operates. Normative ethics entails the prototypes of moral character, duty, and consequences and is referred to as the default model for western philosophy (Copp, 2006). Consequently, nursing ethics has traditionally agreed with the western conceptual view that emphasizes the individual moral actor and what one ought to do (American Nurses Association [ANA], 2015). More precisely, nursing ethics adopts the ideology of virtue ethics with regard to constructing guidelines and codes that deliver a model of character (Windland-Brown, Lachman, & Swanson, 2015). In this way, character alone predetermines a nurse’s responsibility when choosing what is right. Virtue ethics, therefore, appears to present an oversimplified method of using accepted lists of right actions apart from environment or circumstances (Rottschaefer, 2009). In other words, virtue ethics neglects the process of moral deliberation and cases of moral dilemma because the actor is supposed to already possess the right character (Aristotle, trans. 1999). Moreover, virtue ethics doesn’t account for autonomy when the individual does not agree with what is right or feels stress about carrying out what is prescribed as right (Risjord, 2014). When studying the dimensions of nurses as moral agents, the approach ought to include a psychosocial and biosocial context together with principles like a nurse’s motivation and emotional capacity (Rottschaefer, 2009). This is not an attempt to debunk virtue ethics or what has been considered the foundation of the western concept of ethics. Rather, the ubiquitous nature of ethical behavior must be addressed in more than just the context of the individual in order to appreciate it.
Aristotle (trans. 1999) defined virtue as encompassing two complementary halves: intellectual and moral. Understanding and wisdom were his examples of intellectual virtue; this type of virtue was gained by teaching and experience. Aristotle posited that the second type of virtue (i.e., moral virtue) denotes a person’s character. To be virtuous in ancient Greece meant to aim for intellectual excellence as well as to practice personal virtue (i.e., character) through what Aristotle called habits. This ancient philosopher understood the necessity of framing virtue in a dualistic model that describes both its cognitive and emotional natures. Yet, according to Aristotle, the reason for education and practice of virtue is overall happiness. The way of the ancient Greeks was to behave socially in such a manner as to maximize happiness (Aristotle, trans. 1999).

The principle of happiness or consequentialist approach to ethics, however, is inadequate to guide citizens in the present-day complex multi-cultural society. Furthermore, the fact that people often deliberate over moral actions and experience dilemmas suggests that other principles are involved. Additional concepts such as fairness or justice must be considered a part of ethics and moral reasoning.

The proposition of fairness or justice may be briefly reviewed through philosophers Rawls and Kant. In any given society most citizens undoubtedly assume that there is an equal footing of justice among members. John Rawls introduced the concept of social justice behind *The Veil of Ignorance* analogy (Rawls, 1971). This famous thought experiment, cleverly constructed to ensure impartiality, teaches us that if given the chance to establish a just society, we choose to distribute rights and duties fairly. Immanuel Kant claimed that reason dictates that we have the principle of duty as one of the central pillars of ethics (Kant, 1785/1948). In this deontological ethical theory,
Kant opposed acting morally based on feelings or hypothetical consequences. Instead, he stated that an enlightened pure reason prevails to enforce our duty to others as the natural categorical imperative (Kant, 1785/1948). Similar to Kant’s societal view of duty, nursing adopts the dutiful obligation to self and others (ANA, 2015). For nursing, however, the use of reason is not sufficient to understand the interpersonal relationship between nurses and patients. Nurses do indeed reason, but the process of reasoning is not mutually exclusive to cognition (Peplau, 1991). Anyone in an interpersonal relationship gains knowledge by comprehending the condition of the other human being. Emotion and insight are not ignored through the filter of pure reason, nor is consideration for what is virtuous (ANA, 2015). Nevertheless, caution is advised in order to avoid limiting the examination of nursing to critical thinking and character (Newham, 2015).

Interpreting ethics as a matter of virtue, duty, social justice, or by any other means, does not change the fact that nursing is, in essence, an ethical practice. Nursing bears all the weight of a pluralistic society within its unique relationship between caregiver and patient (Van Der Zande, Baart, & Vosman, 2014). Trying to apply the same traditional models of ethics to nursing over time has not helped nursing adapt to societal demands (Dierckx de Casterlé, Izumi, Godfrey, & Denhaerynck, 2008). Nursing leadership has focused on ethics as a problem stemming from competence and education (American Association of Colleges of Nursing [AACN], 2008). Today’s nurses are charged with synthesizing science, business, and care. Nurses must conduct their practice as evidence-based, reconcile care with beneficence, and justify it as cost effective (Dierckx de Casterlé et al., 2008). It is clear in nursing literature that there are continuing problems with moral education, moral competency, and moral distress (Garity, 2009).
When considering nursing ethical issues, both number and intensity are growing as healthcare advances. The American Nurses Association recognizes the increasing complexity of the nurse-patient relationship and has acknowledged the need for ethics education (ANA, 2015). In as much as nursing is inherently an ethical profession, formal training in ethics is not usually a requirement for nursing school graduates. Ethics education is, however, an expected component of nursing school curriculum. For example, in Colorado as in most states, the practice act mandates that education programs shall include ethics (Colorado Nurse Practice Act, 2012). The American Association of Colleges of Nursing’s *Essentials of a Baccalaureate Education in Nursing* has repeatedly charged faculty to foster social justice, ethical reasoning and moral judgment (AACN, 2008). Yet precise details about modalities and the types of ethics (e.g., philosophical theory, bioethics, clinical ethics, or codes) are left unspecified (Garity, 2009). In addition, the National Counsel Licensure Examination (NCLEX) computer adaptive test does not examine nursing graduates for their ethical competency (National Council of State Boards of Nursing, n.d.). Comfort, touch, and solace, considered relational ethics, are merely assumed attributes of nurses (Benner, 2004). There’s no doubt that nursing faculty do try to foster or mentor ethical behaviors. The evidence is apparent in any given nursing program (Numminen, Leino-Kilpi, Isoaho, & Meretoja, 2015). However, ethics education in nursing is typically relegated to guidelines and codes of conduct. Moreover, the dominant education model since the 1970s is exposure ethics integrated throughout curriculum (Park, Kjervik, Crandell, & Oermann, 2012). The concept of nursing ethics is simply not given the same attention and effort as other full academic courses.
Statement of the Problem

The marginalization of ethics education by nursing schools is the result of curricula designs that place a greater emphasis on technical skills. Ethical issues and lessons are undoubtedly sprinkled throughout the nursing school experience when explicit courses are not a part of the curriculum (Callister, Luthy, Thompson, & Memmott, 2009). However, nurses must demonstrate highly technical skills while exhibiting beneficence and promoting autonomy at the same time (Dierckx de Casterlé et al., 2008). In addition, patients and their families often turn to nurses for guidance in any number and level of ethical decision-making situations. Nursing goes far beyond recognizing the physiologic needs of patients. Future nurses will need to identify and act upon ethically infused decision making processes where there is no rubric or decision tree (Monteverde, 2014). Amending ethics education improves professional competencies in all areas that require interactions with patients, families, colleagues, support staff, and other professional disciplines (ANA, 2015).

Modern society’s culturally diverse population and complex health delivery system stimulate ethical predicaments for which today’s nursing graduates may not be prepared (Dierckx de Casterlé et al., 2008; Comrie, 2012). Students learn of the nurse’s advocate role but do not necessarily possess the critical thought and ethical reasoning that give credibility to this position (Dierckx de Casterlé et al., 2008). Studies have shown that philosophical moral dilemmas evolve into a psychological moral stress when nurses experience conflicting duties (McCarthey & Gastmans, 2014). In addition, nurses are at risk for burnout as their moral resilience is burdened over time (Monteverde, 2014). The expectation for nursing students is to assimilate a new role over a short amount of time.
This new role holds the promise of scientific competency together with the ethic of care (Peplau, 1991). The challenge is for nursing schools to meet students where they are in respect to ethics and expose them to current clinical realities (Numminen et al., 2015).

The research question for this study was: in meeting ethics education requirements and competencies, will the addition of an alternative method of ethics instruction - focused ethical case studies and roundtable discussion - prepare baccalaureate level nursing students to deal with ethical dilemmas better than traditional integrated ethics content alone?

**Statement of the Purpose**

The purpose of this study was to determine whether additional focused ethical case studies and a roundtable discussion would increase BSN students’ moral judgment over the traditional methods of nursing ethics education alone. After exposure to ethical dilemmas presented in the case studies, students took the Moral Competency Test designed to measure the intensity of moral judgment.
Chapter II

Review of Literature

Relevant Literature

The purpose of this study was to determine whether additional focused ethical case studies and a roundtable discussion would increase baccalaureate nursing students' moral judgment over the traditional methods of nursing ethics education alone. Literature was reviewed from the domains of nursing, nursing education, nursing theory, ethics education, philosophical theory, and moral psychology. The literature search was conducted using the research database CINAHL, Science Direct Journals, Google search and a review of relevant journals.

The vast majority of research on nursing ethics falls into the domain of improving nursing education based on the difficulties experienced by new nurses. Since the turn of the century, these difficulties have carried the persistent themes of moral distress, moral competency, and moral relativism (Woods, 2005). These topics are studied using multiple methods to identify qualitative concepts and to empirically measure their impact on nurses. These problematic themes in ethics have not gone unrecognized in nursing education (Garity, 2009). However, as a curricular requirement ethics has traditionally been integrated into nursing’s other scientific and practical courses. The philosophical, psychological, and empirical studies of ethics are not usually emphasized in nursing education (Garity, 2009; Woods, 2005; Newham, 2014). Nonetheless, the following moral themes identified throughout nursing research are inseparably affected by nursing education.
Moral distress is a prevalent term first defined in 1984 by philosopher Andrew Jameton (McCarthy & Gastmans, 2014). The term has since evolved to include the psychological elements of a moral dilemma combined with the unique institutional constraints among nursing practices (Morley, 2016).

Related to moral distress is the concept of moral competency. Moral competency is a subjective self-assessment and perception of what affects a nurse’s ability to exercise moral decision-making. Often, moral competency embraces a broader sense of environment that includes psychosocial circumstances beyond the nurse-patient relationship (Numminen et al., 2015).

Although moral relativism is listed as a common theme, this exact term is not often used. Because of the negative connotation and unacceptability of its literal interpretation, the absolute definition has no place in describing any portion of nursing ethics (Coverston & Rogers, 2000). Nevertheless, moral relativism highlights a continuum that implies that nurses regress in a relativistic manner to cope when morally distressed (Woods, 2005). When referring to Kohlberg’s stages of development, Dierckx de Casterlé et al. (2008) found a consistent pattern of falling back on conventions when nurses were confronted with ethical dilemmas. As a result, nurses did not make decisions based on “patients’ personal needs and well-being” (Dierckx de Casterlé et al., 2008, p. 540). Similarly, a recent descriptive study found that new nurse graduates’ relativistic perceptions of competency and ethical environment are correlated with perceived quality of care and job satisfaction (Numminen et al., 2015).

Research aimed at moral themes and the virtuous character of nurses has undergone little change over the past 20 years (Fowler, 1989; Newham, 2014). According
to Fowler (1989), much of the ethical literature of the 1980s involved normative ethics and the obligations nurses carry out under idealistic principles and rules. Focusing on principles is what nursing education continues to rely upon as a governing force to ethical judgment and decision-making (Fowler, 1989; Newham, 2014). The belief is that adhering to universal moral principles like respecting autonomy would both prescribe and justify any moral decisions that follow. There is no perceived gap between thoughts and action. Fowler (1989) noted that the process of nursing ethics and its content are the same. The same analytical and deductive examination of moral decision-making is still a significant part of nursing literature today (Newham, 2014). The assumption is that once nurses apply universal moral principles the clinical action following is simply a logical consequence. Identifying and measuring these universal moral principles among nurses will presumably lead to better planning and implementation for education.

Problematic research findings like moral distress among nurses, however, have not diminished (Garity, 2009; Woods, 2005; Comrie, 2012). Some researchers have shifted focus from universal moral principles to nurses’ moral attributes. More specifically, researchers began looking at nurses’ ability to recognize ethical situations (Comrie, 2012; Jaeger, 2001; Lützén, Dahlqvis, Eriksson, & Norberg, 2006; Park et al., 2012; Van Der Zande et al., 2013). In part, the influence to shift focus came from educators wanting to improve nursing students’ ethical competence (Jaeger, 2001). Additionally, educators were called upon by the 2008 AACN recommendations to prepare baccalaureate nurses to engage ethics in a number of ways (AACN, 2008; Garity, 2009). However, in 2008 the AACN task force on revising the Essentials of a
Baccalaureate Education in Nursing did not include recommendations for instructional methods or curriculum content (AACN, 2008; Garity, 2009).

Nursing education ethics instruction.

Most nursing programs integrate ethics education throughout the curriculum. This traditional approach to ethics education adds yet another indirect requirement to a variety of curriculum objectives. As a result, teaching methods for ethics lack standard core contents as well as systematic approaches to educating new nurses (Park, 2009). In addition, nursing faculty are not afforded the time and resources to devote efforts to teaching ethics. To understand why ethics curriculum is not standardized and why nursing faculty have barriers to teaching, Park (2009) studied the problem from a legal perspective. In other words, one of the research questions was to find the legal requirements of nursing schools to provide ethics education. Licensure and professional education are regulated on the state level. Therefore, Park focused legal research within five states to determine “the legal basis of nursing ethics education” (Park, 2009, p. 107). The states chosen were based on the largest nursing populations (New York, California, Florida, and Texas) and for historical legal influence (North Carolina).

The legislative statutes or practice acts define and set standards for the nursing profession, and the administrative regulations initiated by boards of nursing. From these sources of information, Park (2009) concluded that nursing curricula had to be consistent with the states’ practice acts, however, many of the studied states do not specify ethics curriculum content.

Park adds that the main focus of nursing education is aimed at “technical competencies for licensure,” and because of the many legal and state board requirements
imposed on nursing education, the environment is “highly institutionalized” (p. 107). As an institution, Park (2009) explains, a nursing school strives to maintain a certain degree of legitimacy with its governing entities. Overall, the integrated approach to teaching ethics is a structural barrier due to the institutional demands placed on nursing programs (Park, 2009).

Another approach to the delivery of ethics education includes a course where ethics is a central focus: for example, a nursing issues class encompassing ethics, law, and health policy (Garity, 2009). In an ethics centered course like the one presented by Garity (2009), students are charged with understanding codes, values, critical thinking, and ethical theory. The curriculum proposed suggests a multifaceted problem-based approach. A course in ethics that is highly focused can take the benefits from each of the different methodologies such as debate training and case studies to further understand ethical dilemmas (Garity, 2009). However, the problem with designing an ethics course is that it would not be practical for small nursing schools outside of a “large urban university” (Garity, 2009, p. 114). As a result, some institutions have adopted problem-based learning in place of conventional courses or integrated methods.

Case-based learning instruction uses a situational narrative or story to portray an ethical dilemma in a realistic way (Woods, 2012). Ethics education is significantly enhanced by the case-based method of teaching because it can focus on “domain-specific knowledge” (Harkrider et al., 2012, p. 259). Harkrider and colleagues advocate that the case study approach enhances ethical decision making from the framework of sense-making. Sense-making is a mental model created to help individuals cognitively navigate complex and ambiguous ethical issues (Brock et al., 2008). Harkrider et al., (2012) based
their case study content around professional codes of conduct and forecasting. Forecasting describes how individuals see or predict multiple outcomes and possible actions. For Harkrider and colleagues, the hypotheses predicted that case studies with codes of conduct and forecasting “would lead to (a) more knowledge acquired, (b) higher case satisfaction, (c) greater use of sense-making strategies, and (d) better decision ethicality compared to cases without codes” (Harkrider et al., 2012, p. 267) and forecasting content. Using separate ANOVA, the findings of Harkrider and colleagues indicate an increase in sense-making strategies and statistically significant interaction of using both codes and forecasting on decision ethicality by score of $F=2.23$ Fisher’s Least Significant Difference test $F=2.23, p<.05$.

By exploring cases, students can vicariously experience the ethical dilemmas of others while learning how to navigate the problem on their own. When a case, narrative, or story is reviewed, students participate “as if the unfolding events of the study become a temporary reality for them, and they seem to relive each new development in the story with deep interest” (Woods, 2012, p. 5). Undeniably, case-based education is supported throughout the literature as a practical method (Garity, 2009; Harkrider et al., 2012; Hutchinson, Shedlin, Gallo, Krainovich-Miller, & Fulmer, 2014), and it includes real life events that engage students without an authority figure on whom they may rely. Faculty may facilitate in this peer led method, but students voluntarily step up to continue the dialogue in this colleague-centered learning approach (Hutchinson et al., 2014). What Hutchinson and colleagues learned from bimonthly private ethics round-table sessions highlighted the gap between classroom and clinical education. Students provided feedback, asked questions, and expressed concerns to the non-faculty facilitators about
their clinical experiences. In turn, the facilitators provided recommendations to curriculum committees in charge of integrating ethics education. Overall, case-based education as an alternative approach suggests several benefits.

Determining how to supplement or deliver nursing ethics curriculum will depend on assessed outcomes (Monteverde, 2014). Nursing exists under a very particular set of circumstances; the profession is an exacting place for ethics, and nursing in itself is an ethical profession (Newham, 2015). In order to empirically study on the ground level where nurses practice, researchers have chosen to focus on specific individualized moral attributes of nurses. Again, the theme of moral distress, competency, and relativism are studied via the individual. This approach is consistent with the Western conceptual view that emphasizes the individual moral actor rather than the ethical nature of a group (Copp, 2006). In attempts to understand the framework from which moral choices and behavior stem, researchers have effectively postulated some concepts such as moral sensitivity.

**Moral sensitivity.**

Historically, moral sensitivity can be traced back to the seventeenth century (Lützén, Dahlqvist, Eriksson, & Norberg, 2006) and up through some of the larger figures in the history of philosophy itself. Lützén and colleagues define moral sensitivity as an “attention to the moral values involved in a conflict-laden situation and a self-awareness of one’s own role and responsibilities” (Lützén et al., 2006, p. 189). In other terms, Lützén et al. (2006) describes moral sensitivity as a capacity to distinguish moral problems from other types of problems. Furthermore, this capacity contains the ability to discern between feelings and values as well as to reflect on them. Another way to
describe how nurses may possess this competence is to consider it a perception (Jaeger, 2001). The question that Jaeger asks is how does a nurse perceive moral duty to the patient within an institution that also dictates some form of this obligation. In other words, how are moral imperatives assessed outside of professional obligation? Lützén et al. (2006) and Jaeger (2001) posit that moral sensitivity is not the same as moral reasoning, but is, in fact, the precursor. Moral sensitivity is the ability to recognize when there are moral implications, and moral reasoning is the validation for acting or deciding.

Lützén et al. (2006) furthers the development of an instrument to measure moral sensitivity with a revised tool called the Moral Sensitivity Questionnaire (MSQ-R) (Lützén et al., 2006). One apparent shared intention in the literature is to shed light on the discrepancy between education and clinical practice. By examining that part of ethics that presupposes ethical behavior, like moral sensitivity, researchers hope to find and universalize such a quality as a measurable outcome (Monteverde, 2014). Lützén and colleagues constructed their MSQ-R in light of psychometric theory. Nine elements, or “assumptions” were identified as representing the meaning of moral sensitivity (Lützén et al., 2006, p. 190).

The study participants were two convenience samples from a health care conference and a hospital. In addition, a principal component analysis was computed resulting in three factors identified as sense of moral burden, moral strength, and moral responsibility (see Table 3) (Lützén et al., 2006, p. 191).

Using a philosophically influenced theoretical framework Lützén and colleagues went on to further define and explain these moral abilities and attitudes within hypothetical situations. In addition, the possibilities of influencing factors were addressed
to indicate that this study showed that moral sensitivity was more than a cognitive capacity. Despite methodological weaknesses the main conclusion reached was that the MSQ-R was reliable instrument for evaluating moral sensitivity. There was no retest done or accounting for participants who did not complete or return the questionnaire. Furthermore, since the questionnaire was left for anyone to pick up from an information booth, the demographics were a mix of physicians and nurses.

Kim and colleagues (Kim, Kang, & Ahn, 2013) examined the application of the Code of Ethics for Nurses in Korea. The study was a descriptive survey involving a convenience sample of nurse participants \( n=303 \) in clinical settings. A Korean Moral Sensitivity Questionnaire (KMSQ) was adapted from the MSQ developed by Lützén et al. (2006). The participants were asked to assess the application of the code to their own clinical experiences. The results indicated a statistically significant correlation between nurses’ application of the code of ethics and the moral sensitivity of the nurses (Kim et al., 2013). Interpreting these types of results is a conundrum: is moral sensitivity enhancing the effectiveness of an ethical code or vice versa? To understand why researchers like Kim and his colleagues chose moral sensitivity is to comprehend more about what ethics is and is not. Stripping away the high ideal buzzwords within codes of conduct raises the question, what is it that motivates one to think and act on behalf of another even before there is an external guidance? By studying moral sensitivity, or other moral attributes, it is postulated that researchers will develop a heuristic tool to study moral knowledge (Van Der Zande et al., 2014). Ultimately, this analytical approach aspires to contribute to a theory of nursing ethics.
The problem with the objectives of Lützén et al., (2006) was the fact that they sought to develop the concept rather than measure a process. Setting up a hierarchy where moral sensitivity is more significant or important than moral reasoning and judgment is arbitrary. In other words, researchers since Lützén et al. (2006) are positing a type of moral literacy. This method of correlating such minute details would be analogous to over-interpreting an infant smiling at someone: more specifically, if the researcher construes the baby’s smile as facial recognition versus a simple amusement or mimicking response.

Researchers continue to support their concept of moral sensitivity as an empirical way of examining nursing practices (Park et al., 2012). At the same time, however, they avoid calling it moral judgment by describing it as “practical wisdom – both a resource and process” (Van Der Zande et al., 2013, p. 75). In addition, researchers acknowledge that the term moral sensitivity has been used differently in different studies (Comrie, 2012).

What nursing seeks to understand is the manner in which nurses engage in moral judgment necessary for decision-making (Dierckx de Casterlé et al., 2008). Both moral sensitivity and reasoning are encompassed as judgment propelled by recognition of moral implications and by justifications for action (Jaeger, 2001). The emphasis ought to be the process that generates an action over and above a tacit recognition of sentiment. Similarly, in moral psychology the dichotomous nature of moral judgment as affect and intuition is contrasted with cognition and reasoning to illustrate the driving psychological forces (Doris & Stich, 2014). In addition, Doris & Stich (2014) suggest that the best approach to research moral judgment is to include both cognition and psychological
processes as a dual-process model. The revised Moral Sensitivity Questionnaire (MSQ-R) instrument originally developed by Lützén et al., (2006) has been modified and adapted to each of the different ethnicities and health care populations studied (Park et al., 2012). Because of the multiple versions of the MSQ-R and the varied conceptual differences regarding moral sensitivity, the researcher followed moral judgment as the most significant tenet of nursing ethical decision-making.

**Psychological Theoretical Framework**

A noteworthy portion of moral development research stems from the work of Lawrence Kohlberg and his Stages of Moral Development. Kohlberg devised a theoretical framework that successfully accounted for moral reasoning as a result of cognition together with the affective aspects of behavior (Bužgová & Sikorová, 2013). Kohlberg’s stages of moral development represent levels individuals reach by internalizing social conventions and controls. The six sequential stages are as follows (Kohlberg, 1984; Doris & Stich, 2014, p. 215):

**Level A: Preconventional**

- Stage 1 = Punishment and Obedience
- Stage 2 = Individual Instrumental Purpose

**Level B: Conventional**

- Stage 3 = Mutual Interpersonal Expectations and Conformity
- Stage 4 = (Preserving) Social Order
Level C: Post-conventional and Principled Level

Stage 5 = Prior Rights and Social Contract or Utility
Stage 6 = Universal Ethical Principles.

These six stages of moral development are helpful in correlating how nurses make ethical decisions using moral reasoning. Moral reasoning involves the application of justice and the balancing of interests within the context of a profession desiring to engage at least the post-conventional level (Dierckx deCasterlé, Roelens, & Gastmans, 1998).

The criticism of Kohlberg’s theory of moral development has long been the contention that it is tightly based on social justice while ignoring the ethics of care (Gilligan, 1982). Indeed, Gilligan’s ethics of care represents the context of nursing as having a more interpersonal nature. However, identifying various rationalizations to account for moral behavior does not lend well to testability. The empirical evidence and generalizability of Kohlberg’s theory provides the relevant foundational elements for continued research (Dierckx deCasterlé et al., 2008). Educators need to know not only what curriculum to address, but also to whom they are addressing. In other words, in order to improve the ethical decision making of nursing students, instructors need to meet students at their base level. Considering moral judgment as stemming from a particular stage or level is useful in education because it lends itself to measuring. It stands to reason that if new nurses are in need of increased moral competency, then the traditional method of integrated teaching is insufficient. Adding alternative methods of ethics instruction ought to increase moral judgment in a way that is both beneficial and measurable.
Key Words

Moral Competency is defined as the ability and capacity to recognize moral circumstances, apply reason, and exercise judgment while balancing self-interest against societal and environmental influences.

Ethical Decision-Making refers to the applied ethics of examining, revising, and deepening the understanding of moral deliberation.

Moral Distress occurs when individuals are prevented from acting on their moral judgment due to institutional and social constraints.

Ethical Dilemmas are the interpersonal situations that cause discomfort due to the difficulty reconciling feelings, moral reasoning, and judgments between oneself and others in the setting that is often constrictive.

Ethics Education encompasses intellectual instruction and emotive guidance for fostering students’ critical examination of personal and professional applied ethics.

Moral Judgment is the product of moral reasoning and defines the parameters of right and wrong.

Moral Psychology is the interdisciplinary, empirical, and philosophical field of investigation that studies the actions and thought processes of people in moral contexts.

Moral Reasoning refers to internal personal deliberation and reflective rational thought as well as to the external negotiation, argument and justification to others.

Moral Sensitivity is a perception-like capacity to distinguish moral problems from other types of problems.
Chapter III

Method

Description of the Research Design

The purpose of this study was to determine whether additional focused ethical case studies and a roundtable discussion would increase baccalaureate nursing students' moral judgment over the traditional methods of nursing ethics education alone. Using an experimental design, nine (9) students were placed in the experimental group and nine (9) in the control group by random selection. All participants completed a moral competency questionnaire pre- and post-discussion. The control group did not participate in the ethics roundtable discussion but were offered the opportunity after the study was completed. The goal was to answer the research question: in meeting ethics education requirements and competencies, would the addition of an alternative method of ethics instruction - focused ethical case studies and roundtable discussion - prepare BSN students to deal with ethical dilemmas better than traditional integrated ethics content alone.

Utilization of the experimental design allows a researcher to control the independent variable to study its influence upon the dependent variable between groups of students. The independent variable was the roundtable discussion of ethical case studies. The dependent variable was level of ethical understanding as measured by the Moral Competency Test (MCT). Advantages of the experimental design were the ease of data collection and the means of comparing pre- and post-questionnaire results. Another general advantage of an experimental design includes ease of manipulating the independent variable to easily identify the variables of cause and effect. The method used
in this study could be reproduced easily and repeated to check results, thereby increasing the validity of the study.

**Protection of Human Subjects**

Before recruiting subjects for this study, approval was obtained from the University’s Institutional Review Board (IRB) (See Appendix A for IRB approval). This ensured the protection of all subjects participating. This investigation was performed according to the standards of the University and Department of Nursing.

Each participant was assigned a subject number. Signed consent was obtained from the experimental and control groups before any data was collected. Each subject was informed that participation in this study was voluntary and that they could refuse or discontinue participation in the study at any time without negative consequences (See Appendix B for consent form).

Overall potential risk of harm associated with human subjects participating in this study was low. Physical risk was minimal as participants were simply invited to sit at a table to discuss ethical issues and to complete a written survey. Psychological risk was also negligible because participants voluntarily gave demographic information and personal opinions that have little to no risk as well. Lastly, there was minimal risk socially since students who chose not participate were given the opportunity to do so outside of the study environment at a later time. Therefore, no privileges or favors were given to study participants. Recruitment was solicited from students voluntarily with no payment, gift, or grade incentives.

The information obtained from the participants will be kept confidential and managed according to the requirements of the IRB. Consent forms and questionnaires are
stored in a locked desk drawer in the researcher’s home. All confidential documents will be maintained for five years and then destroyed by the researcher.

**Identification of the Population and Sample**

Eighteen senior nursing students in a Southern Colorado university BSN program, who have completed the course Nursing 420 Care of the Adult III and who have been exposed to traditional ethics curriculum integrated throughout their coursework, comprised the study population. Nine students were randomly assigned to the experimental group and nine students were randomly assigned to the control group. Demographics reflected a positively skewed frequency distribution due to the homogeneous sample of mostly young, white, female nursing students.

**Instrument**

The paper-based Moral Competency Test (MCT) is a Likert-type, eight-point scale ranging from strongly reject or disagree (-4) to strongly accept or agree (4) (see Appendix C for Moral Competency Test).

The MCT provides a way to measure the degree to which a person’s judgment is influenced by his/her moral principles. A computed index or C-score represents an “ability to judge arguments according to their moral quality (rather than their opinion agreement or other factors)” (Lind, 1999, p. 3). Two case scenarios were presented in the MCT with questions that offer basic arguments in favor of or contrary to suggested ethical actions. The participants indicated their level of agreement or disagreement on the 8-point scale. The C-scores were categorized in ranges of low, medium, high, and very high to roughly correlate with stages of moral development.
Procedure

This experimental study involved randomly dividing 18 senior BSN students into an experimental group (9 students) and a control group (9 students). Each student was assigned a participant number. The elements of informed consent were delivered in writing and in an oral presentation, which stressed the fact that potential study subjects had complete autonomy regarding their decision to participate or not to participate. Study participants were asked to complete a 28-question survey examining ethical understanding by measuring moral judgment. The survey instrument took approximately 30 minutes to complete. All students completed the pre-intervention questionnaire. The experimental group then participated in a half-hour ethical case study dialogue using a round-table discussion method. Both the experimental and the control group completed a post-intervention questionnaire.

*Case Studies in Nursing Ethics* (Fry, Veatch, & Taylor, 2011) provided the framework for the roundtable discussion. Using a problem-based approach, students analyzed two scenarios with life-like ethical conflicts that have occurred in nursing practice (see Appendices D – E for Ethics Case Study 11-4 and Ethics Case Study 15-6). The aim of discussion was not to solve an ethical problem, but rather to exercise critical thinking. During the roundtable discussion, the researcher took responsibility to facilitate discussion by utilizing the Socratic method of inquiry (Audi, 1995). More specifically, when participants struggled to rationally explain their views or when discussion paused, the researcher asked questions. In keeping with the Socratic method, these questions were deployed to both probe and help participants explore their views, judgments and conclusions.
Data Analysis

The researcher, in consultation with a doctorally-prepared statistician, analyzed the scores of the MCT using the Mann-Whitney U-test, and the Wilcoxon test to determine any statistically significant differences between the experimental and the control groups related to ethical understanding and moral competence. Results are presented in Chapter IV.
Chapter IV

Results

The purpose of this study was to determine whether additional focused ethical case studies and a roundtable discussion would increase baccalaureate nursing students' moral judgment over the traditional methods of nursing ethics education alone. Results were organized by three analyses of the Moral Competency Test (MCT). The first analysis addressed the main research question with regard to the pre- to post-survey differences between groups. More specifically, identifying measurable difference in students’ raw scores on the MCT between the experimental and control groups. The second analysis focused on questions 27 and 28 (time and level of difficulty of the test) to compare group responses concerning only these two questions. The choice to compare the last two questions on the MCT was due to the subjective topics about time and level of difficulty rather than any ethical inquiry. The third analysis involved the C-index (C-score) calculation, which is computed analogously to a multivariate analysis of variance (MANOVA). Comparing C-scores indicates whether there is a difference between groups concerning the extent of moral competency.

Analysis of the data began with creating difference scores for each participant. These scores were created by separately deriving the mean of all 28 questions for each individual person on the pre-and post-surveys; each person’s pre-survey score was then subtracted from their post-survey score. Next, the difference scores were used as the dependent variable in a Mann-Whitney U-test, and the independent variable was group (treatment and control). The U-test, rather than a t-test, was used because of the small group sizes (n=9 in each group). Table 1 provides the mean pre-, post-, and difference
scores for each group. Note that these are provided for descriptive purposes only, since the U-test relies on ranks rather than means. Results of the U-test indicate there was no statistically significant difference in the difference scores between the experimental and control groups ($U = 36.00, p = .690$).

Table 1
*Descriptive Statistics by Group*

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th></th>
<th>Experimental</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Difference score</td>
<td>-0.07</td>
<td>0.33</td>
<td>0.02</td>
<td>0.26</td>
</tr>
<tr>
<td>Pre-score</td>
<td>0.57</td>
<td>0.58</td>
<td>0.29</td>
<td>0.66</td>
</tr>
<tr>
<td>Post-score</td>
<td>0.50</td>
<td>0.66</td>
<td>0.30</td>
<td>0.63</td>
</tr>
<tr>
<td>Q 27 pre</td>
<td>3.89</td>
<td>3.10</td>
<td>2.44</td>
<td>2.19</td>
</tr>
<tr>
<td>Q 27 post</td>
<td>3.44</td>
<td>2.65</td>
<td>2.67</td>
<td>2.00</td>
</tr>
<tr>
<td>Q 28 pre</td>
<td>10.56</td>
<td>3.91</td>
<td>8.56</td>
<td>4.61</td>
</tr>
<tr>
<td>Q 28 post</td>
<td>5.56</td>
<td>2.24</td>
<td>5.67</td>
<td>3.04</td>
</tr>
</tbody>
</table>

Question (Q); Standard Deviation (SD)

A second analysis compared the pre- to post-scores on questions 27 (respondents’ rating of difficulty in answering the question) and 28 (respondents’ self-report of estimated time to complete the test) for each group. This analysis examined whether there was a significant difference between pre- and post-scores for each group separately on each question. Differences were examined using the Wilcoxon test, rather than a paired samples t-test, because of the small group sizes.

Table 2 includes results for each group. The Z-score shows the number of standard deviations a score is from the mean of zero; more specifically, the Z-score is
negative when it is below the mean, and it is positive when it is above the mean. The Z-scores of each group for questions 27 and 28 were then compared in order to examine whether they were statistically significantly different. It is generally accepted that a Z-score that differs two or more standard deviations from the mean is statistically significant. As indicated by the $p$-scores, the pre- to post-difference for question 27 was not statistically significant for either group. In other words, respondents in both groups similarly rated their difficulty in answering the questions. For question 28, however, the difference was statistically significant for both groups. Both groups reported that they took statistically significantly less time to complete the test questions the second time (i.e., post-survey).

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th></th>
<th>Experimental</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$Z$</td>
<td>$p$</td>
<td>$Z$</td>
<td>$p$</td>
</tr>
<tr>
<td>Q 27</td>
<td>-1.63</td>
<td>0.10</td>
<td>-0.53</td>
<td>0.59</td>
</tr>
<tr>
<td>Q 28</td>
<td>-2.41</td>
<td>0.02</td>
<td>-2.21</td>
<td>0.03</td>
</tr>
</tbody>
</table>

A third analysis examined the possibility of measuring the extent of moral competency used when assessing the arguments or behavior indicated in the MCT questions. The C-score range is 1 to 50 with 1-9 considered low, 10-29 as medium, and 30-49 as high in regard to a person’s moral concerns about a given moral argument or behavior. C-scores were calculated for each participant as per instructions and syntax provided by the MCT manual (Lind, 1999). Table 3 below includes the mean pre- and post-survey C-scores disaggregated by group, the difference scores (post- minus pre-),
and the respective standard deviations. On both the pre- and post-measures, the experimental group showed lower C-scores than the control group. The differences between groups at both pre- and post-measurement were not significant (pre-, \(t = .426, p = .676\); post-, \(t = .496, p = .626\)).

Turning to the difference scores, both groups on average saw a decrease in C-scores from pre- to post-survey. The experimental group saw a greater decrease than the control group. The difference between groups, however, was not significant as analyzed with either parametric (\(t = .064, p = .949\)) or non-parametric tests (\(U = 40.00, p = .965\)). Therefore, the experimental group showed no increased use of moral concerns and judgment after exposure to the intervention or participation in the case study discussions.

Table 3. Pre- to Post-C-score Comparisons by Group

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treatment</td>
</tr>
<tr>
<td>C score pre</td>
<td>17.27</td>
<td>15.19</td>
</tr>
<tr>
<td>C score post</td>
<td>16.00</td>
<td>13.62</td>
</tr>
<tr>
<td>C score difference</td>
<td>-1.27</td>
<td>-1.57</td>
</tr>
</tbody>
</table>

**Limitations**

The primary threat to this study is sample size. The small number of participants from a single southern Colorado university reduces statistical power and prevents generalizing the results to the larger population. The small sample size also raises the possibility of a statistical Type II Error. Statistical analysis in these situations may fail to show a causal relationship where one may in fact exist (Polit & Beck, 2014).

The possibility of bias was introduced because the discussion facilitator for the intervention was also the primary researcher. In addition, the roundtable intervention was
a one time limited event. The intervention itself may not have been strong enough in its duration or intensity to cause a significant difference.

Furthermore, it is conceivable that the case scenarios discussed with the experimental group were not unique. Nursing students at the study university may have already been exposed to similar moral dilemmas or situations within their traditional curriculum. However, it is presumed that by selecting senior nursing students that their level of experiential morality would be relatively uniform.

A potential weakness from survey questions is the fact that there is no neutral answer. In other words, it is assumed that everyone is an equally capable moral agent. There is no accounting for indecisiveness and every participant will record a response even if it does not accurately reflect her/his actual level of moral competency.
Chapter V

Conclusions and Recommendations

Conclusions

The purpose of this study was to determine whether additional focused ethical case studies and a roundtable discussion would increase baccalaureate nursing students' moral judgment over the traditional methods of nursing ethics education alone.

Eighteen senior nursing students attending a southern Colorado university were randomly assigned into an experimental or control group. The Moral Competency Test (MCT) consisting of 28 survey questions was administered to the experimental and control groups prior to the intervention and again immediately afterward. The intervention for the experimental group was a group discussion of two ethical case studies. *Case Studies in Nursing Ethics* (Fry, et al., 2011) was used to provide the participants with realistic ethical issues in order to engage decision-making and stimulate discussion.

A three-part analysis of the results of the MCT was conducted to determine any differences between groups concerning a general pre- and post-score, differences in time or effort, and differences between moral judgment as reflected by the C-score index. The first analysis indicated no significant statistical differences in the general scores between groups.

The second analysis of questions 27 (self-report of difficulty level) and 28 (length of time spent) indicated no significant difference in pre- to post-test scores in regard to rating the difficulty with answering the test questions. The analysis of question 28, however, indicated a difference was statistically significant for both groups. In other
words, both groups reported that they took statistically significantly less time to complete the test questions the second time (i.e., post-survey). This finding may indicate that participants were not as thoughtful in their answers with the post-test or were in a hurry to finish due to time constraints.

The third analysis calculated a C-score where both groups saw a decrease in C-scores from pre- to post-survey. A higher C-score indicates a participant’s increased moral deliberation. Although the experimental group saw a greater decrease than the control group, the difference between groups was not statistically significant as indicated by parametric ($t = .064, p = .949$) or non-parametric tests ($U = 40.00, p = .965$). Therefore, the experimental group’s lack of significant change from pretest to posttest scores indicated no increased use of moral competency after exposure to the intervention.

This study design, coupled with the conceptual framework of moral competency, raises possibilities for future research, and the potential for meaningful follow up study is encouraging because the limitations are not insurmountable. This study presumably contributes to the use of consistent methods and procedures relevant to moral competency assessment. As a result, replicating this study could provide an effective template for ongoing research. Furthermore, it supports the provision of methods that nurse educators can employ to positively impact development of moral competency.

**Recommendations**

In order to increase validity and reliability of this study, several issues need to be addressed in future research. First, the study needs a larger sample size of senior nursing students. Recruiting students from several universities throughout the region or state would accomplish this objective. Moreover, a larger sample size would likely make the
study more representative of the general nursing student population in terms of age and
gender; consideration of students’ demographics adds valuable data that impact study
implications. Second, the intervention should occur over a greater length of time to
ensure it more fully engages the study participants. Third, a nurse educator or someone
other than the researcher should present the case scenarios. Using an independent third
party to present and facilitate the group discussion during the intervention ought to
decrease bias. Finally, the study design may be improved by assessing participants’
moral competence at both the beginning and end of nursing baccalaureate programs. The
instrument used in this study to assess moral competency, the MCT, can be used to
measure improvements. Since ethics education is most commonly addressed by
integrating it throughout the nursing curriculum, the MCT could reveal deficits in novice
nurses’ ethical development.

Summary

This study is theoretically sound and offers great potential to support nursing
education once the limitations are addressed. As a pilot study, this research suggests
possibilities that offer enhanced understanding of nursing ethics education. Future studies
need to advance a protocol that measures moral competence as the universal entity of the
decision making process.

Current moral distress and ethical competency issues in clinical practice continue
to alert nursing leadership. Future nurses will need to identify and act upon ethically
infused decisions where there is no rubric or decision tree (Monteverde, 2014).
Amending ethics education improves professional competencies in all areas that require
interactions with patients, families, colleagues, support staff, and other professional
disciplines (ANA, 2015). Therefore, more research that focuses on the examination of moral competence and ethics education is needed.

Fostering ethical competence in nursing will lead to continued research that is pragmatic to nursing education and practice. Perhaps with the help of education, philosophy, and psychology, the deconstruction of moral concerns will result in a more precise comprehensive theoretical framework as well as advances in moral education of baccalaureate nursing students.
References


Woods, M. (2005). Nursing ethics education: Are we really delivering the good(s)? *Nursing Ethics, 12*(1), 5-18. http://dx.doi.org/10.1191/096973305ne7540a
1.8.16
IRB Review
Proposal Title: Comparison of Traditional and Alternative Methods of Ethics Instruction
Principal Investigator: Mertz
New application for Nursing

Dear Daniel,

Thank you for submitting the IRB application “Comparison of Traditional and Alternative Methods of Ethics Instruction”. This application has been reviewed according to the policies of this institution and applicable federal regulations. The review category for this application is Exempt. This letter serves as notification that you now have IRB approval for a period of 12 months from the date of this letter. The expiration date for your approval is 1.8.17. Once human research has been approved, it is the Principal Investigator’s responsibility to report any changes in research activity related to the project, including revisions or amendments, serious adverse consequences, renewal or completion. If you have any questions, please contact me at barbara.brettgreen@csupueblo.edu. Thank you for your concern regarding the protection of human subjects, and good luck with your research.

Best regards,

Barbara Brett-Green, Ph.D.
IRB Chair
Appendix B

Consent to Participate in a Research Study
Colorado State University

TITLE OF STUDY: Comparison of Traditional and Alternative Methods of Ethics Instruction in Baccalaureate Nursing Programs

PRINCIPAL INVESTIGATOR: Daniel J. Mertz, BSN, MSN candidate 2016, Nursing Department, dj.mertz@pack.csupueblo.edu; 970-317-7031

CO-PRINCIPAL INVESTIGATOR: None

WHY AM I BEING INVITED TO TAKE PART IN THIS RESEARCH? You are asked to be a part of this research because the study is about ethics education in Nursing. Participants must be 18 years of age or older and a senior nursing student in a baccalaureate nursing program that teaches ethics within standard curriculum.

WHO IS DOING THE STUDY? The principal investigator who is a graduate student in the Nursing Department is conducting this study. This research study is being completed in partial fulfillment to obtain a master’s degree in science with a major in nursing in the Nurse Practitioner (PMHNP) track at Colorado State University Pueblo.

WHAT IS THE PURPOSE OF THIS STUDY? You are being asked to participate in a research study to compare traditional and alternative methods of ethics instruction in baccalaureate nursing programs.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST? The study will take place after your regularly scheduled class. You will be asked to complete a 28-question survey before and after you experience a group discussion regarding nursing ethics.

- The survey should take approximately 10 to 15 minutes.
- The group discussion should take approximately 30 minutes.

WHAT WILL I BE ASKED TO DO? You will be assigned into one of two groups of 15 students.

- Each of two groups will take a written survey twice, regarding nursing ethics.
- The second group will take the written survey before and after participating in a group discussion concerning nursing ethics.
ARE THERE REASONS WHY I SHOULD NOT TAKE PART IN THIS STUDY?
You will be asked to complete a survey in a seated area and participate in a group discussion lasting 30 to 45 minutes. The process is completely voluntary and there are no reasons to exclude you unless you do not want to participate.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
- Senior nursing students are exposed to real-life situations in the clinical area as part of their education and are accustomed to dealing with sensitive situations.
- The case studies used in this study may cause psychological discomfort; however, these case studies are no different than what is used in typical nursing courses, such as NSG 420.
- It is not possible to identify all potential risks in research procedures, but the researcher(s) have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

ARE THERE ANY BENEFITS FROM TAKING PART IN THIS STUDY?
Your participation in this study will provide evidence and information related to nursing education. While there is no intended direct benefit for you, your contribution could benefit nursing education in the future.

DO I HAVE TO TAKE PART IN THE STUDY? Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled. There will be no negative impact on any course grade if you choose not to participate. The participants will engage in the ethics roundtable discussion only once during the semester.

CONFIDENTIALITY- The Case Studies used in this research, by nature, are no different than case studies and small group discussions used in every class throughout the nursing program. Students are aware that these discussions are not confidential.

WHO WILL SEE THE INFORMATION THAT I GIVE? The data we collect is confidential. We will keep private all research records that identify you, to the extent allowed by law. For this study, we will assign a code to your data, such as, the last four digits of your student identification number. Therefore, the only place your name will appear in our records is on the consent and in our data spreadsheet which links you to your code. Only the research team will have access to the link between you, your code, and your data. The only exceptions to this are if we are asked to share the research files for audit purposes with the CSU Institutional Review Board ethics committee, if necessary. When we write about the study to share with other researchers, we will write about the combined information we have gathered. You will not be identified in these written
materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

CAN MY TAKING PART IN THE STUDY END EARLY? You may be required to stop before the end of the study for any of the following reasons:

- If all or part of the study is discontinued for any reason by the investigator or university authorities.
- If you fail to adhere to requirements for participation established by the researcher.

WILL I RECEIVE ANY COMPENSATION FOR TAKING PART IN THIS STUDY? No, you will not receive any compensation or gifts for participating. Participation will also not affect any of your course grades.

WHAT IF I HAVE QUESTIONS? Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions about the study, you can contact the investigator, Daniel Mertz at 970-317-7031. If you have any questions about your rights as a volunteer in this research, contact the CSU IRB at: RICRO_IRB@mail.colostate.edu; 970-491-1553. We will give you a copy of this consent form to take with you.

Your signature acknowledges that you have read the information stated and willingly sign this consent form. Your signature also acknowledges that you have received, on the date signed, a copy of this document containing 3 pages.

_________________________ ________________________
Signature of person agreeing to take part in the study Date

_________________________
Printed name of person agreeing to take part in the study

_________________________ ________________________
Name of person providing information to participant Date

_________________________
Signature of Research Staff
Appendix C

The Moral Competence Test (MCT)*

© Copyright for this and all other language versions
by Georg Lind¹ 1977 - 2014 (last revision of this text: Nov 15th, 2014)
* formerly called Moral Judgment Test (MJT), German: MUT

The holder of the copyright for all versions of the Moral Competence Test (MCT) is the author, Dr. Georg Lind. The authors of translated versions hold a co-copyright. The joint copyright for translated and cer- tified versions of the MCT is with the author of the translated version.

When used in research and evaluation studies, each copy of the test must bear this copyright note: “© 1977-2013 by Georg Lind, http://www.uni-konstanz.de/ag-moral/” plus the name of the author of the translated version.

A list of validated and certified versions of the MCT is to be found on the web: http://www.uni-konstanz.de/ag-moral/. The standard version of the MCT must not be altered without written consent by the author.

The use of the MCT for research and education in public institutions is free. All other usage (for example, by private institutions and commercial projects for program evaluation and alike or by privately financed projects) require written permission of the author.

The MCT is designed for research and for the evaluation of programs and policies only. It is not designed as an instrument for evaluating people, groups of people or individual institutions, or for the use as a high-stakes test. Such use represents a case of misuse. The MCT can be applied with participants with average schooling from age of 11 years upward. Disadvantaged subjects may require some adaption of the administration of the MCT.

The MCT has been constructed on the basis of Lind’s Dual Aspect Theory of moral judgment and development to assess subjects’ moral judgment competence. Though it uses Lawrence Kohlberg’s (1964, p. 425) definitions, the MCT employs a different psychological and psychometric theory. For more details please visit this web-site: http://www.uni-konstanz.de/ag-moral/.

In pretest-posttest-studies, test weariness may be a problem, resulting in a lowering of the C- score on the retest. The following instruction helps to avoid this problem: “Some of the questions will be the same as you have been given the first time. We want to know whether your thoughts have changed. Please fill them out as sincerely as you did the first time.”

This version of the MCT, which has been in use since 1977, was slightly revised in December 2001, replacing “acceptability” judgments by “acceptance” and “rejection” judgments, and in June 2007, modifying the language of the stories (of the English version only) for more reading ease using the Flesch-Kincaid grade level formula. I wish to thank Dr. Michael Hauan and Mrs. Kirsten Byrnes, respecti- vely, for their suggestions.

Change (July 31, 2009): Old: “The doctor complied with the wish of the woman.” New: “The doctor decided to give her an overdose of morphine“. I felt that we cannot know whether the doctor “complied” or did it for other reasons.

Correction (Feb. 5, 2015): Item 15, missing word “ignore” added in the question.

Note: Do not publish this test without written consent by the author.

¹Contact: em. Prof. Dr. Georg Lind,E-mail: Georg.Lind@uni-konstanz.de.
Web site: http://www.uni-konstanz.de/ag-moral/
Sample instruction

Dear participant,

On the following pages you will find two short stories. In both stories someone has to make a decision. You will be asked: What do you think about that decision?

   After each decision you will find reasons pro and contra this decision.

You will be asked: Do you agree with these reasons or reject them?

   Please respond to all questions. Do not skip any. There is no time limit. But do hesitate too long, either.

   Please do not write down your name anywhere.

I will repeat this survey with you sometime. In order to able to couple your answers I need some information. Enter always two letters or digits only.

Please turn over

(Instruction for second MCT administration, e.g. in evaluation studies)

What follows are the two stories, which you know already. You will also be given the same questions as the first time, so we can see whether your responses have changed.

Please turn over
Workers

Recently a company fired some people for unknown reasons. Some workers think that their bosses are listening in on their private conversations through cameras and microphones in the building and using the information against them. The bosses say that they are not listening in.

The workers cannot legally do anything until they can prove that their bosses are listening in on their conversations. Two workers then break into the main office and take the tapes that prove their bosses were listening in.

1. Would you agree or disagree with the workers' action.

<table>
<thead>
<tr>
<th>I strongly disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>-3</td>
<td>-2</td>
</tr>
<tr>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

How acceptable do you find the following arguments in favor of the two workers' action? Suppose someone argued they were right for breaking in . . .

2. because they didn’t cause much damage to the company.

<table>
<thead>
<tr>
<th>I strongly reject</th>
<th>I strongly accept</th>
</tr>
</thead>
<tbody>
<tr>
<td>-4</td>
<td>-3</td>
</tr>
<tr>
<td>-2</td>
<td>-1</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

3. because the company did not follow the law that says that they should not listen in, the actions of the two workers were allowed to bring back law and order.

<table>
<thead>
<tr>
<th>I strongly reject</th>
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4. because most of the workers would approve of their action and many would be happy about it.

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5. because trust between people and individual dignity count more than the company’s rules.

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6. because the company had done something wrong first by listening in, the two workers were right in breaking into the main office.

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7. because the two workers saw no legal ways of proving the company misused their trust by listening in, and therefore chose what they considered the lesser of two evils.

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How acceptable do you find the following arguments against the two workers’ actions? Suppose someone argued they were wrong for breaking in . . .

8. because if everyone acted as the two workers did, we would be going against law and order in our society.

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9. because a person must not break such a basic right as the right to protection of property and take the law into one's own hands, unless there is universal moral principle that says it is o.k. to do so.

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10. because risking getting fired from the company in order to help other workers is not very smart.

11. because the two workers should have used all the legal ways available to them without breaking a law.

12. because a person doesn't steal if he wants to be considered decent and honest.

13. because the firing of other workers had nothing to do with them, the two workers had no reason to steal the tapes.
A woman had cancer and she had no hope of being saved. She was in terrible pain and was so weak that a large dose of a painkiller such as morphine would have caused her to die. During a brief period of improvement, she begged the doctor to give her enough morphine to kill her. She said she could no longer stand the pain and would be dead in a few weeks anyway. After some thinking, the doctor decided to give her an overdose of morphine.

14. Do you agree or disagree with the doctor’s action?

I strongly disagree  I strongly agree

15. because the doctor had to act according to his conscience and what he believed was right. The woman's pain made it right for the doctor to ignore his moral obligation to preserve life.

16. because the doctor was the only one who could do what the woman asked; respect for her wish made him act the way he did.

17. because the doctor only did what the woman talked him into doing. He does not need to worry about negative consequences.

18. because the woman would have died anyway and it didn't take much effort for him to give her an overdose of a painkiller

19. because the doctor didn't really break the law. Nobody could have saved the woman and he only wanted to shorten her suffering.

20. because most of his fellow doctors would most probably have done the same thing in a similar situation.

How acceptable do you find the arguments presented against the doctor’s action?

Suppose someone said that he acted in a wrong way. . .

21. because he acted opposite to other doctors’ beliefs. If the rest of them are against mercy-killing, then the doctor shouldn't have done it.

22. because a person should be able to have complete faith in a doctor's commitment to save every life even if someone with great pain would rather die.

23. because protection of life is everyone's highest moral duty. We have no clear moral way of telling the difference between mercy-killing and plain murder.

24. because the doctor could get himself into a lot of trouble. Other doctors were punished before for doing the same thing.

25. because he could have had it much easier if he had waited and not interfered with the woman's dying.

26. because the doctor broke the law. If a person thinks that mercy-killing is illegal, then one should refuse such requests from the patient.
27. How difficult was it for you to fill out this questionnaire?

28. Roughly how much time did it take you to fill it out?

Thank you!
Appendix D

SEDATING AND RESTRRAINING THE DISTURBED PATIENT
Case Study 11-4

Percival Guthrie was a 58-year-old man with a history of organic brain syndrome. In good physical health, Mr. Guthrie had been admitted to a nursing home by his family. Because of his forgetfulness, wandering behavior, sleep pattern disturbances, and inability to care for himself, his family wanted him to be in a care center that would meet his growing needs for supervision and personal care. Family members had tried to care for him themselves during the past year, but they were exhausted from all the supervision that Mr. Guthrie needed. Despite the expense, they hoped that their relative would be happy in the nursing home and that he would receive the care that they could no longer give him.

Sandra Mooney was the day nursing supervisor of the nursing home. Recognizing the extent of the care that Mr. Guthrie would need, she agreed to place him in a room near the nurses’ station and to observe him while he adjusted to the routine of the nursing home. Adjustment, however, seemed an impossibility for Mr. Guthrie. It soon became apparent that his wandering into other patients’ rooms was disturbing to them. During meals, he talked loudly and frequently called for his relatives. When sedated with a mild tranquilizer, Mr. Guthrie became more agitated and spent all night roaming the halls, wandering into the rooms of sleeping patients, and generally exhibiting loud and boisterous behavior, much to the dismay of the nursing staff. Within a few days, it became apparent that mild medication was not going to affect Mr. Guthrie’s behavior. He was also becoming very dirty and refused to change his clothes. Once, he sat in his armchair all night and failed to use the bathroom to urinate. His clothes and the chair were soaked with urine, and this became a daily occurrence.

Faced with the constant odor emanating from Mr. Guthrie’s room, his wandering behavior, his unkempt appearance, and his loud talking, Mrs. Mooney considered confining the patient to a room at the end of the hall. She discussed the problem with the nursing staff, and they decided to use a combination of sedation and confinement, recognizing that their one attempt at confining Mr. Guthrie to his room had resulted in loud behavior that disturbed the other patients and the staff and alarmed visitors. It was a course of action that Mrs. Mooney chose reluctantly, given the good physical condition of Mr. Guthrie. Yet it seemed that his liberty would have to be restricted if the staff and the other patients were to have a satisfying nursing home atmosphere.

WHO DECIDES FOR THE DYING PATIENT?
Case Study 15-6

Mr. Burntree, a 67-year-old, was admitted by his internist to the medical/surgical unit with the diagnosis of probable bowel obstruction. Mr. Burntree had a history of two myocardial infarctions, chronic obstructive pulmonary disease (COPD), and arteriosclerotic heart disease (ASHD). A surgeon was consulted, and Mr. Burntree underwent surgery in the late afternoon. A cancerous growth was removed from his colon, and a permanent colostomy was performed. He returned to the unit several days later (a Friday afternoon), alert, oriented, and aware of his condition. He was receiving IV fluids at 125 ml/hr, and he had a Foley catheter in place. His urinary output for the previous 8 hours had been only 200 cc. Both the internist and surgeon were aware of this fact.

During visiting hours, Mr. Burntree was visited by Miss Scanlon, a woman friend with whom he had made his home for the past 10 years after being divorced for about 6 years. Miss Scanlon was very attentive toward Mr. Burntree and quite concerned about him. Later in the afternoon, Mr. Burntree’s daughters called the nurses’ station. They talked with Liz Holden, the evening charge nurse. The daughters were from out of town and were requesting information regarding their father’s condition. Both seemed unaware of their father’s postoperative diagnosis. Miss Holden advised the daughters that his condition was stable and that they could talk with their father on his room telephone.

By the end of the 3:00 to 11:00 shift, Mr. Burntree’s urinary output was a total of 85 cc. Miss Holden contacted the resident on call (both the internist and the surgeon were signed out to their respective partners for the weekend) and received orders to give Mr. Burntree Lasix IV and to increase his IV fluids to 166 ml/hr.

By the next afternoon, Mr. Burntree’s condition had deteriorated significantly, and his urinary output had failed to increase significantly during the night. The resident was notified during the day, and he ordered Lasix IV, oxygen per nasal cannula, and the insertion of an NG tube to low suction. Given the patient’s diagnosis and condition, the day nurse requested a DNR order. The resident refused, citing his unfamiliarity with the patient, his family, and his friend. By early evening, Mr. Burntree was extremely restless and confused, at one point pulling off his oxygen cannula and trying to climb out of bed. Within an hour, the patient was diaphoretic and extremely lethargic, with Cheyne-Stokes respirations. The resident was notified, but no additional orders were given, and he did not come to visit Mr. Burntree. At this time, Mr. Burntree’s daughters called again for a report on their father’s condition. The daughters were adamant that they wanted everything done for their father and that they would arrive at the hospital within 3 to 4 hours.

Mr. Burntree’s friend, Miss Scanlon, who had been visiting him all afternoon and evening, talked to Miss Holden and stated that she just wanted Mr. Burntree kept comfortable. She did not want any heroic measures taken. Mr. Burntree had apparently shared his diagnosis with her, and because he had COPD, he had asked that he not be kept “hooked up to any machines” in order to live. Miss Holden assured Miss Scanlon that she would record this information and notify the physician on call.

Before she could reach the physician by phone, Mr. Burntree arrested. Whose directions, if any, should Miss Holden follow? the daughters’? or the friend’s?

CURRICULUM VITAE

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Master of Science in Nursing, 2016
COLORADO STATE UNIVERSITY PUEBLO
December 2016

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Psychiatric Mental Health Nurse Practitioner emphasis
Thesis: Effect of Adding Alternative Methods of Ethics Instruction
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Bachelor of Arts, University of California at Santa Cruz, 1999
Major in Legal Studies and Philosophy, concentration in Ethics

TEACHING EXPERIENCE

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Anatomy and Physiology Laboratory

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Thesis defense Colorado State University, November 2016
Ethics symposium series facilitator on academic integrity,
Johns Hopkins University School of Nursing, 2011 to 2012
Graduate philosophy colloquium presenter, University of Montana, 2000

SERVICE / PROFESSIONAL ACTIVITIES

Neuroscience Education Institute, Psychopharmacology Congress, 2016
American Association of Nurse Practitioners, 2014 to present
Northern Colorado Nurse Practitioner Coalition, 2013 to present
Ethics committee, Johns Hopkins University School of Nursing, 2012
Curriculum Committee, Class of 2012 Student Representative,
Johns Hopkins University School of Nursing, 2011 to 2012
Disabled American Veterans, Lifetime Member