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The effect of ethical ideology and professional values on registered nurses' intentions to act accountably

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The Effect of Ethical Ideology and Professional Values on
Registered Nurses' Intentions to Act Accountably

by

Susan R. Hartranft

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
College of Nursing
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moral distress

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Dedication

To my husband, Tom, who has supported me throughout my pursuit of this degree. This support came in several forms and never faltered. He took over parenting duties, transporting our children to and from school, practices and games. He made lunches and picked up dinners. He encouraged me when I was discouraged. He was a source for statistics help and when stats progressed beyond what he knew, he read the book and completed the homework so he could look at my work and say "it's not what I got"... forcing me to review my work and find my mistakes.

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The Effect of Ethical Ideology and Professional Values on Registered Nurses'

Intention to Act Accountably

Susan R. Hartranft

ABSTRACT

Hospitals today focus on creating a culture of patient safety and reducing error. Registered nurses are mandated by the American Nurses Association's Code of Ethics to advocate for the patient at all times and to act accountably to ensure patient safety. There is a paucity of literature relating to how nurses' values and ethical ideology may affect their decision to act accountably.

This study tested two hypotheses. Hypothesis 1 predicted that registered nurses who demonstrated a low relativistic ethical ideology would score higher on a measure of professional values than would registered nurses who demonstrate a high relativistic ethical ideology. Hypothesis 2 predicted an order of ethical ideology (absolutists then exceptionists, subjectivists and situationists) in scores on a measure of accountability.

A descriptive non experimental design was used. Registered nurses (n=215) employed on the west coast of Florida completed a demographic form, Ethical Position Questionnaire (EPQ), Nurses Professional Values Scale Revised (NPVSR) and an investigator developed accountability instrument. A median split on the scores of the relativism and idealism scales on the EPQ formed the four groups of ethical ideology; absolutists, exceptionists, subjectivists and situationists.

The accountability instrument consisted of 2 hypothetical clinical vignettes involving a late antibiotic administration. Using a Likert type scale, the participants answered three questions regarding how likely they would be to record the actual time of medication administration, call the physician and complete an incident report.

Hypothesis I was not supported. Idealism ($p=.001$) not relativism had a significant effect on professional values. Hypothesis II was not supported. Absolutists scored highest on measures of accountability followed by exceptionists, situationists and subjectivists. When controlling for age, idealism not relativism had a significant effect on completing an incident report ($p = .03$).

This is the first study to examine the effect of ethical ideology on professional values and a registered nurse's intention to act accountably. Previous studies described values held but did not link the descriptions to intentions to act. The information may be useful to hospitals as they build a culture of patient safety and develop a workforce that is accountable for its actions and decisions.

Chapter One

Introduction

Hospitals have focused on creating a culture of patient safety since the inception of the Institute for Healthcare Improvement in 1991 as well as the publication of *To Err is Human* (Kohen, 2000) and its companion publication of *Crossing the Quality Chasm* (Institute of Medicine, 2001). Although specific federal legislation has not been enacted to address the need for a culture of patient safety (Sharpe, 2004), 11 states to date have enacted some form of nurse staffing legislation (American Nurses Association, 2008). The Joint Commission in charge of the certification of hospitals has also adopted standards to establish a safe hospital environment. One reason hospitals seek Joint Commission certification is to be able to participate in federal Medicare and Medicaid reimbursement programs with deemed status (Joint Commission, 2008; Jost, 1994). This deemed status forces hospitals to create a safe patient environment. Creation of a safe environment for patients focuses on reducing error. Hospitals accomplish this through development of policies and procedures based on standards of care, and by examining faulty processes that create error (Bayley, 2004; Morreim, 2004; Sharpe). This is in contrast to previous cultures in health care in which individuals were believed to be the cause of error (Sharpe).

The policies and procedures developed to create the safe patient environment include personnel policies and clinical procedures. These policies and procedures define the institutional expectations of the registered nurses

conduct while at work. One such policy would define the window of time available to the registered nurse to administer medications and have the medications considered by policy to be “on time.” The policies that define “on time” medication administration are based on the physician’s order for timing of administration (Allen & Barker, 1990). For ease of scheduling, hospitals adopted standard administration times (FitzHenry, Peterson, Arrieta, & Miller, 2005). The registered nurse records the actual time of medication administration in the medical record. The hospital’s expectation is that the medical record would show the medication administered within the accepted times, usually one hour before or after the ordered time. These institutional expectations may create a conflict of values for registered nurses if they are not able to provide medications to their assigned patients as they have been instructed and, at the same time, meet the institutional expectations.

In addition to standards of care, hospital policies and procedures, the registered nurse may be influenced by professional values. Professional values are those values held as important and integral to the profession. These values may attract individuals into the profession, where they learn the values through the socialization process during professional education and upon entering the workforce (Jameton, 1984; Steele, 1983). For nursing, professional values are delineated in the American Nurses Association *Code of Ethics* that first was developed in 1950 with the latest revision occurring in 2001. The *Code of Ethics* defines “relevant ethical obligations and duties nurses have not only to the public but to themselves” (Fowler, 2008, p.43).

When registered nurses perceive conflict between their employer's expectations and their own professional values, some have been shown to misrepresent their actions (Grover 1993a, 1993b) or to abandon their values (Ham, 2004). When the conflict becomes too complex to resolve, some nurses may leave their employment (Hart, 2005; Kupperschmidt, 1998; McNeese-Smith & Crook, 2003).

Given the complexity of caring for critically ill hospitalized patients and the emphasis on cost effectiveness and patient safety, the potential for values conflict in the hospital setting is inevitable. Although the values conflict could be manifested in many ways such as calling in sick, extending breaks or leaving the organization, Grover (1993a, 1993b) found registered nurses who scored low on a measure of moral development misrepresented their actions when faced with a conflict between their professional values and organizational expectations. If registered nurses choose to misrepresent their actions by recording in the medical record the expected and not the actual time of administration, the potential for patient harm may increase. This creates an unsafe environment in institutions whose mission is care, comfort and healing.

Statement of the Problem

The medical record is a document in which the potential conflict of professional values and organizational expectations may be demonstrated. From an ethical standpoint, when a registered nurse fails to meet organizational and professional expectations, it is considered a breach of duty. A medical record provides the factual documentation of a patient's hospitalization and his or her

care. Because decisions regarding medical care and treatment are made based on the information contained in the record, it is assumed by health care workers that all information entered in this document is accurate. For example, hospitals have standard policies for times that medications are to be administered. Such policies typically state that medications will be given within one hour on either side of the established time. A medication to be given at 10:00 could be administered within a time range of 09:00 to 11:00 and still be considered “on time.” With the number of medications received by patients and the number of patients for which the registered nurse may have responsibility, it is estimated a nurse could administer up to 50 different drugs in one shift (Rassin, 2007).

It is challenging to deliver the volume of medications within the time frame that constitutes on time medication administration. When medications are administered outside the time frame dictated by policy and procedure, it is considered a medication error committed by the nurse. Nursing errors are “expressed as breaches of either nursing content or of nursing role authenticity (nursing identity)” (Biordi, 1993, p. 39). Elfering (2006) found that medication errors are ranked second in safety-related stressful events for registered nurses.

When faced with a medication error, it is often tempting for a registered nurse to record a time of administration that falls within the expected parameters despite the fact that he or she actually administered the medication outside the expected parameters. Under such circumstances, the medical record would be a misrepresentation of the actual behavior. For the registered nurse, this misrepresentation may create a value conflict that is labeled in the literature as

moral distress (Pendry, 2007) or ethical distress (West, 2007). Moreover, such value conflict may create an unsafe environment for the patient.

The American Nurses Association (ANA) *Code of Ethics* (2001) provides a framework of ethical behavior for practicing registered nurses. Additionally, it addresses the nurse's duty to ensure patient safety and to follow institutional guidelines to report errors (ANA, 2001). Nurses, however, continue to be challenged to make ethical decisions in numerous clinical situations, leading to values conflict. Varcoe et al. (2004) identified this as working the "in-betweens." Nurses described working between their own values and those of their employing institution. One way to understand these values conflicts would be to determine the state of a practicing registered nurse's ethical ideology and the strength of his or her professional values.

Once the registered nurse's ethical ideology and strength of professional values are established, the extent to which the registered nurse demonstrates one particular value, such as accountability, could be assessed by way of a hypothetical but realistic clinical scenario of a late medication administration. Accountability was chosen as the focus of this study because it is the value registered nurses must demonstrate in all facets of their work environment. A medication administration scenario was chosen to assess accountability because it is a task a registered nurse performs many times during a shift. It is reasonable to expect that a registered nurse has faced situations in which a medication is late because he or she did not administer it within the established time frame for an "on time" medication. In this situation, the registered nurse must decide what

time to document in the medical record. She or he could document either the actual time of administration or the time that the medication was scheduled for administration. If a registered nurse records the expected time of administration and not the actual time, it may have implications for patient safety and efficacy of treatment. The implications would be related to the timing of the medication effect. For example an antibiotic is timed to maintain a steady blood level of medication. When an antibiotic is administered late but the medication is documented as being administered on time and the patient begins to demonstrate signs of worsening infection, the physician may assume the antibiotic is not effective and change it to another. Additionally because of the late medication and the re-emergence of symptoms, the patient's hospital stay and recovery may be prolonged. With the knowledge regarding registered nurses' documentation related to medication administration time, hospitals can develop policies and procedures and improve staffing, which may assist registered nurses in their clinical practice and provide a safer environment for patients.

Conceptual Model

The conceptual model for this study, illustrated in Figure 1, consists of three concepts: (a) ethical ideology, (b) professional values, and (c) accountability. The model illustrates the effect of ethical ideology on accountability. Similarly, the model illustrates the impact of ethical ideology on the development of the nurses' professional values. Additionally, the influence of

nurses' professional values is illustrated in the model. The purpose of the study is embedded in this relationship.

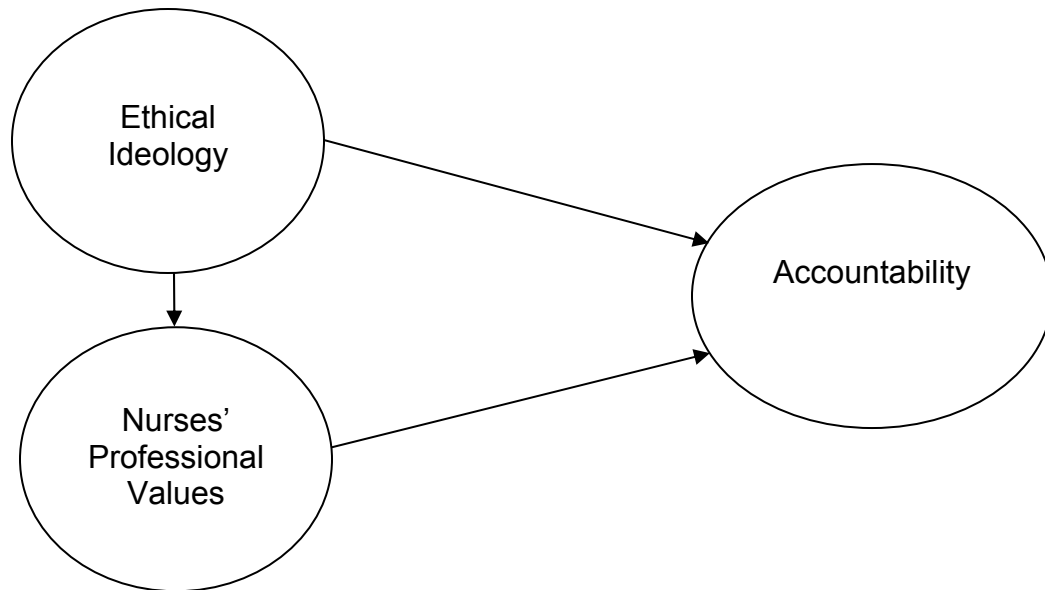


Figure 1. Conceptual model

Conceptual Definitions

Ethical ideology consists of the degree of relativism (use of universal moral rules) and idealism (belief that good can come of all situations) exhibited by individuals when they make an ethical decision (Forsyth, 1981). A highly relativistic individual would reject moral principles to analyze situations individualistically. Someone who follows universal moral principles or rules would be an individual low in relativism. The Ethical Position Questionnaire (Forsyth, 1981) measures ethical ideology by categorizing the respondents as high or low in the ethical terms of relativism and idealism, thus allowing them to be further

categorized into one of four ethical taxonomies: Situationist, subjectivist, absolutist, and exceptionist (see Table 1).

Table 1

Taxonomy of Ethical Ideology

	High Relativism	Low Relativism
High Idealism	Situationist Rejects moral rules; advocates individualistic analysis of each act in each situation; relativistic	Absolutist Assumes that the best possible outcome can always be achieved by following universal moral rules
Low Idealism	Subjectivist Appraisals based on personal values and perspective rather than universal moral principles; relativistic	Exceptionist Moral absolutes guide judgment but pragmatically open to exceptions to these standards; utilitarian

The process of moral judgment or ethical decision making has its origin in an individual's ethical ideology. Ideology is composed of the ethical terms of relativism and idealism. Relativism is the extent to which an individual accepts or rejects universal moral rules. Idealism is the belief that decisions can be made that will please those affected by the decision (Forsyth 1980, 1981, 1985; Forsyth & Pope, 1984). The relativistic individual does not rely on universal moralistic

principles to make ethical decisions but rather on his or her own personal belief system that may shift based on the situation. Idealistic individuals believe desirable consequences can be achieved without violating ethical guidelines. These guidelines may be universally accepted ethical principles or their own personally developed guidelines. Ethical ideology as defined by Forsyth develops when the ethical groups of relativism and idealism are divided into high and low, thus forming the four ethical taxonomic groups illustrated in Table 1.

A situationist is highly idealistic and relativistic. A situationist would reject universal moral rules and individually analyze each act in each situation making the decision that would maximize the good or minimize the bad.

In contrast a subjectivist is highly relativistic and low in idealism. The subjectivist, like the situationist, will examine situations using his or her own moral principles and not universally accepted principles. Unlike the situationist, subjectivists are not idealistic and do not believe that good will result from all decisions.

Absolutists are low in relativism and high in idealism. Absolutists believe in using universal moral principles to guide decisions. They believe good will always result when universal principles are used.

The exceptionist is low in both relativism and idealism. An exceptionist will use universal moral principles when making decisions but would be willing to consider exceptions to these universal principles to lessen the negative effects of the decision.

In a situation such as a late medication administration, where conflict between nursing role performance and hospital policy is involved, registered nurses identified as situationists, by using their own moral principles as a guide, might choose to act in the way that will bring the greatest good. If the patient was not suffering any ill effect from the late medication administration, the situationist would most likely document the actual time the medication was administered. By choosing this action the patient does not suffer and the situationist does not come under scrutiny from their employer.

In contrast a registered nurse identified as a subjectivist might consult his or her own personal belief system to resolve the conflict. Consideration of bringing about the greatest good would not enter the decision-making process for a subjectivist. The subjectivist would document the expected and not the actual time of medication administration.

An absolutist might follow universal moral principles or professional values such as the *ANA Code of Ethics* to resolve the conflict in the belief that this will serve the “greater good.” Therefore an absolutist would document the actual time of administration whether the patient was suffering any ill effects or not.

While an exceptionist might consider the *ANA Code of Ethics*, if another possible solution is available that makes the conflict resolution easier for all involved, the exceptionist will consider other principles and choose the more practical solution. So the exceptionist would probably document the actual time of administration if the patient was experiencing adverse effects from the late

medication administration. If the patient was not suffering adverse effects the exceptionist would document the expected time of administration.

Professional values for nursing are the values identified by the ANA *Code of Ethics with Interpretive Statements*. The *Code of Ethics* “is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession. It is the profession’s nonnegotiable ethical standard and it expresses nursing’s own understanding of its commitment to society” (ANA, 2001, p 5). The *Code of Ethics* is composed of nine provisions with accountability defined in Provision 4. The nurse is accountable for individual practice. The interpretive statement for Provision 4 further defines accountability as:

to be answerable to oneself and others for one’s own actions. In order to be accountable, nurses act under a code of ethical conduct that is grounded in moral principles of fidelity and respect for the dignity, worth, and self-determination of patients. Nurses are accountable for judgments made and action taken in the course of nursing practice, irrespective of health care organizations’ policies or providers’ directives (p. 16).

Hypotheses

The following hypotheses were tested in the study:

1. Registered nurses who demonstrate a low relativistic (absolutist or exceptionist) ethical ideology will score higher on a measure of professional values than will registered nurses who demonstrate a high relativistic (situationist or subjectivist) ethical ideology.

2. Absolutists are more likely to act accountably in hypothetical clinical situations than exceptionists. Exceptionists are more likely to act accountably than are subjectivists and subjectivists are more likely to act accountably than are situationists.

Purpose of the Study

The first purpose of this study was to identify the influence of ethical ideology on the professional values held by registered nurses. The second purpose was to determine the extent to which registered nurses demonstrated the professional value of accountability when faced with hypothetical medication administration clinical situations. This study examined the relationship among ethical ideology, professional values, and accountability. Further, it represented the next step in descriptive research, which was to examine if professional values and ethical ideology are predictive of registered nurses' behavioral intentions to act accountably in hypothetical clinical situations.

Significance of Study

Despite a more than a 100-year history of research on the values held by nurses and nursing students, there were no published generalizable descriptive data that would create a picture of the values held by the typical registered nurse. There were no published clinical data to support an assumption that registered nurses in clinical situations would demonstrate values they claimed to hold. Development of professional values begins with the educational preparation for entering the profession, thus the American Association of Colleges of Nurses (1998) has identified core knowledge of ethics, including accountability for own

practice, as desirable for baccalaureate nursing students to hold at graduation. The National League of Nursing Accrediting Commission (NLNAC), which accredits all levels of nursing education programs, expects nursing education programs to prepare practitioners to meet professional standards (NLNAC, 2008). Among those professional standards is accountability as identified in the *ANA Code of Ethics*. According to the code, the nurse is accountable for making appropriate decisions regarding practice even if the nurse perceives that his or her actions would be counter to institutional policies and procedures. The code directs the nurse to comply with all laws regarding licensure and delegation.

It would be useful for health care facilities, in the interest of patient safety, to determine if all registered nurses have internalized this value of accountability. If they have not, it will be necessary for employing organizations to have this information in order to facilitate the development of processes that support the nurse, meet regulatory guidelines, and assure patient safety.

Summary

This chapter presented the background, purpose, conceptual framework, conceptual definitions, and significance of the study. Chapter Two presents the review of literature for the concepts of ethical ideology, nurses' professional values and accountability.

Chapter Two

Review of Literature:

Introduction

Registered nurses employed in hospital settings may find themselves struggling with the conflicting expectations of their employers and their individual professional values (Varcoe et al., 2004). When this occurs, some registered nurses may be inclined to misrepresent their actions (Grover, 1993a; 1993b). The medical record is a place where this conflict may be manifest. Decisions regarding treatment are based on the information contained in the medical record. A falsified medical record does not present an accurate picture of the patient's response to medical treatment. When decisions are made based on falsified information patient safety may be compromised. Currently the literature holds only descriptive data that would create a picture of the values held by the typical registered nurse. There appears to be a lack of data to support the idea that registered nurses in clinical situations actually demonstrate the values that they claim to hold. Research is necessary to advance the current knowledge in this area. This chapter presents a review of the relevant literature pertinent to the three concepts of ethical ideology, professional values and accountability that form the basis for this study.

Ethical Ideology

The review of ethical ideology literature begins with a review of the process of moral development. Moral development must occur before an ethical

ideology is realized. Dewey (Archambault, 1964) was the first to suggest that moral development occurred in stages. He suggested that individuals take a rational approach to the personal decisions required when faced with moral conflict, and that academic education is for the purpose of moral development and to provide the optimum environment for that learning.

Piaget (Ketefian, 1981a) recognized moral development as occurring in three stages. For Piaget, intellectual development and moral development took place on a parallel course. When individuals reach Piaget's highest level of moral development, the autonomous stage, they follow rules not because they "have to" but because of their free will to do so, bolstered by their use of principles and rules to guide behavior.

Like the other pioneers in this area, Kohlberg (1981) defined three global stages of moral development: pre-conventional, conventional, and post conventional. In the post conventional level of development, the individual autonomously examines and defines moral values and principles apart from group norms and culture. Cognitive growth is necessary along with moral growth to move to higher levels of moral development. Because of the cognitive factor necessary for moral development not all individuals will reach the post conventional stage.

Gilligan (1977) proposed three global stages for moral development. Although she states her work is "based on theme and not gender" (p. 2) she writes her goal is to "expand the understanding of human development by using the group left out in the construction of theory to call attention to what is missing

in its account” (p. 4). Gilligan’s first stage is characterized by focus on self for individual survival. She then posits a transitional phase where the focus goes from selfishness (concentration on self) to responsibility. Phase two is characterized by goodness (watching out for and caring about others; self sacrifice) being equated with self satisfaction. The transition to phase three is the movement from goodness to truth. In phase three, moral development is achieved through focus on deliberately uncovering self-needs and contemplating the effect of self-sacrifice on self and others (Gilligan, 1982; Belknap, 2000). Unlike Dewey, Piaget and Kohlberg, Gilligan did not assign chronologic age to her phases of development but instead focuses on changes in sense of self.

Ketefian (1981a) studied nurses and nursing students and found “a significant and positive correlation between critical thinking and moral reasoning” (p. 171). Ketefian (1981b) also found a positive relationship between moral reasoning, knowledge and valuing moral behavior in nursing dilemmas. In addition she found a relationship between moral reasoning and the nurse’s perception of realistic moral behavior in nursing dilemmas.

All four theories of moral development and decision contain three stages for moral development. Moreover, each contains a description of related cognitive maturation. The level of moral development achieved will determine the individual’s response to moral dilemmas.

Although the theories of moral development provide a process for ethical decision making, they do not elaborate on the decision-making process. Forsyth (1981) proposed a decision-making model based on one’s ethical ideology. This

model has been used to evaluate ethical decisions in several areas, including business (Cui, 2005; Davis, 2001; Douglas, 2007; Ho, 1997; Sommer, 2000; Tansey, 1994), education (Deering, 1998), and religion (Watson, 1998). Studies using the Ethical Position Questionnaire (EPQ) were descriptive in nature comparing Russian and American businessmen (Sommer, 2000), Egyptian and American managers (Douglas, 2007), British and American undergraduate education students (Deering, 1998), consumers in Austria, Britain, Bruni, Hong Kong and the United States of America (Cui, 2005). These authors found ethical ideology as measured by the EPQ was not affected by nationality. Tansey (1994) found that moral judgments of life insurance agents related to their personal moral philosophies. In a search of the available literature, none regarding nurses' ethical decision making using the Ethical Position Questionnaire was found.

The process of moral judgment or ethical decision making is based on an individual's ethical ideology. Ideology is composed of relativism and idealism. Relativism is the extent to which an individual accepts or rejects universal moral rules. Idealism is the belief that decisions can be made that will please those affected by the decision (Forsyth 1980, 1981, 1985; Forsyth & Pope, 1984). The relativistic individual does not rely on universal moralistic principles to make ethical decisions but rather on his or her own personal belief system that may shift based on the situation. Idealistic individuals believe desirable consequences can be achieved without violating ethical guidelines. These guidelines may be universally accepted ethical principles or their own personally developed guidelines.

Each of the ethical ideologies can be compared to a specific category of ethical philosophy and are illustrated in Table 2. The highly relativistic individuals (situationists and subjectivists) are characterized as ethical skeptics, meaning they do not attempt to endorse specific moral principles. The situationists would support Fletcher's (1966) situation ethics, which is a contextual approach to action rather than "good" or "bad." Subjectivists would be categorized as ethical egoists because of their practical approach to evaluating their actions (Forsyth, 1980). In contrast, individuals with low relativism (absolutists and exceptionists) do use moral or ethical guiding principles. Absolutists, because they reject consequences as a decision-making strategy and believe that moralistic principles or rules are the foundation for all actions, are compared with the deontological approach to moral philosophy. Exceptionists can be compared to Teleologist philosophy, which contends the morality of an action depends upon the consequences produced by the action (Forsyth, 1980).

In a clinical situation such as the decision to remove a patient from life support, the individuals with low relativism (absolutists and exceptionists) will use the ethical principles of justice, nonmaleficence, autonomy and beneficence to make their decision. The absolutist because of their idealistic beliefs would use beneficence as their primary principle. The highly relativistic individuals (situationists and subjectivists) would not consult ethical principles but would consider the situation, such as the patient's age, family situation or the conditions under which the patient was placed on life support. Furthermore, the situationist would consider how a good outcome can be achieved.

Table 2

Taxonomy of Ethical Ideologies with Ethical Philosophy

	High Relativism	Low Relativism
	Situationist/Situation Ethics	Absolutist/Deontological
High Idealism	Rejects moral rules; advocates individualistic analysis of each act in each situation; relativistic	Assumes that the best possible outcome can always be achieved by following universal moral rules
	Subjectivist/Ethical Egoist	Exceptionist/Teleological
Low Idealism	Appraisals based on personal values and perspective rather than universal moral principles; relativistic	Moral absolutes guide judgment but pragmatically open to exceptions to these standards; utilitarian.

Values

Values are beliefs that guide behavior to the end of an action that is deemed desirable. Values have a cognitive, affective, motivational, and behavioral component. Values guide individual behavior (Rokeach, 1973). Once a value is internalized it becomes consciously or unconsciously a standard for guiding action, judging self and comparing oneself to others (Steele, 1983). Personal values develop from life experiences and usually remain consistent

through life although they can be modified based on later life experience (Jameton, 1984; Rokeach, 1973; Steele, 1983).

Professional values develop through the education process, which is designed to prepare individuals for entry into the profession (AACN, 2008; Alfred, 2005; Bjorkstrom, 2007; Martin, 2005). Professional values development is believed to continue past graduation and entry into the profession (O'Neill, 1973; Thurston, 1989; Vincent, 1993). The individual will enter professional education with personal values developed from his or her life experiences (Bjorkstrom, 2007; Horton, 2007); therefore a review of the personal values literature will precede the review of the professional values literature.

Personal values. Historically, the study of values held by nurses began with the study of nursing students to identify characteristics that would be desirable in a nurse. These identified characteristics included physical and mental health, maturity, modesty, trusting, loyalty, and comforting (Eads, 1936; Holliday, 1961; Ingmire, 1952; MacAndrew, 1959). Only one author in these early studies (Miles, 1933) identified intelligence as a desirable characteristic.

In the ensuing years, there was considerable interest in describing the personality characteristics of nursing students, often in comparison to non-nursing students. The Edwards Personal Preference Schedule Inventory was used in nine studies to describe the personality of nursing students. In seven of the studies (Bailey & Claus, 1969; Grossack, 1957; Levitt, Lubin, & Zuckerman, 1962; Redden & Scales, 1961; Schulz, 1965; Smith, 1968; Stein, 1969), results were essentially the same. Nursing students in both baccalaureate and diploma

programs scored higher than non-nursing college students on the concepts of deference, nurturance, intraception (to be interested in motives and feelings; to analyze the feelings of others) and endurance (Levitt, 1962) The nursing students scored lower than non-nursing college students in the measures of autonomy, dominance, and exhibition (to be the center of attention). Based on these findings, the ideal student nurse would be described as respectful, sympathetic to others, persistent, introspective, conventional, a follower and one who shuns attention. In 1970, Adams and Klein administered the Edwards Personal Preference Schedule to baccalaureate nursing students and, for the first time, the nursing students did not score significantly differently than non-nursing college students on measures of endurance. The current nursing students scored essentially the same as previous nursing student groups on exhibition, dominance and change.

Kahn (1980) found no significant difference between baccalaureate nursing students and non-nursing college students on the autonomy and deference scale of the Edwards Personal Preference Schedule. Scores on autonomy increased and deference scores decreased for baccalaureate nursing students when compared to previous studies. Earlier studies (Burns, 1978; Sullivan, 1978; White, 1975) showed nurse practitioners' scores on the Edwards Personal Preference Schedule were lower on deference and higher on autonomy than previous undergraduate students. Kahn suggested that this finding supported a change in the profile of nursing students on the scales. However the

small number of participants in Kahn's study precludes generalization of a major change in personality characteristics in baccalaureate nursing students.

In the 1960s and 1970s, researchers became interested in the personal values held by nursing students. There was interest in whether students chose the appropriate program for their values (Dustan, 1964), whether nursing students held different values than female college students in general (O'Neill, 1973; Redman, 1966), whether values change during nursing education (May & Ilardi, 1970), and whether there had been a change in values over a decade (Garvin & Boyle, 1985). All of these researchers used the Allport-Vernon-Lindzey (AVL) scale to measure the values held by nursing students. The scales in the AVL measure the following six basic value types: theoretical, economic, aesthetic, social, political and religious (May & Ilardi, 1973). The scales are interdependent so an increase in the score on one scale will create a decrease in another.

The social and religious values of the Allport-Vernon-Lindzey Scale were considered to represent traditional nursing values. Nursing students consistently identified religious values as the most important value, while social values scored second. The one exception to this was the associate degree nurses in Dustan's (1964) study who indicated social values were more important, with religious values being second. Nursing students in all studies scored higher than the general female college population on the religious and social scales (Dustan; O'Neill, 1973; Redman, 1966). In one longitudinal study, nursing students'

religious value score decreased during the education process; this was the case even though it was still the highest-ranking value (May & Ilardi, 1970).

Two research studies (O'Neill, 1975; Redman, 1966) compared the scores of faculty and students on the Allport-Vernon-Lindzey Scale. In Redman's study the faculties' scores indicated values different from the students' scores. For faculty, the highest score was the aesthetic score (the aesthetic person values beauty and harmony), followed by the theoretical score and the religious score, respectively. Redman hypothesized that either a decrease in the social score represented an absolute decrease in other values, or it represented a supplanting of values, such as by theoretical values (discovery of truth), which are more important to the teaching role. O'Neill found the greatest agreement between values held by faculty and students during the students' junior year. O'Neill expected greatest agreement would occur in the senior year after the students had maximum exposure to faculty. Academic achievement did not predict agreement between values held by the students and faculty. This might indicate that faculty interaction in the classroom may not influence value development. O'Neill suggested the faculty provide opportunities to help students identify their values.

Garvin and Boyle (1985) used the Allport-Vernon-Lindzey Scale to compare the values of nursing students entering the baccalaureate program in 1982 with the values of nursing students who entered the baccalaureate program in 1972. The only significant difference found was that the class of 1982 scored significantly higher on the economic scale (valuing what is useful and practical).

The significant change in the economic scale was believed to be indicative of the current economic times. In keeping with what are considered to be typical nursing values, both groups ranked social values highest; religion ranked third in 1972 and second in 1982. The theoretical scale (discovery of truth) was rated higher than the political scale in both groups.

The Rokeach Value Scale (Rokeach, 1973) was used in three studies to measure the values held by nursing students. This scale is used to assess the respondents' ranking of 18 instrumental and 18 terminal values.

Instrumental values measure preferred modes of conduct, for example, capable, broad-minded, logical and loving. Terminal values measure preferred end state of existence such as, an exciting life, mature love, inner harmony and true friendship. Terminal and instrumental values are interdependent (Rokeach, p. 119).

Blomquist, Cruise, and Cruise (1980) used the Rokeach Value Scale to measure the values of sophomore and senior baccalaureate nursing students at four universities. The purpose of the study was to see if there was a difference in values between students in religious and secular schools. There were significant differences in 15 of the 18 instrumental values and 10 of 18 terminal values. The authors found a significant difference between freshman and senior students in 10 of the 18 instrumental values and seven of the terminal values. All students valued honesty, with the score increasing between freshman and senior year. The instrumental values of helpfulness and cleanliness decreased through the educational process for all students. This was surprising because the basic

tenets of helpfulness and asepsis are so important in nursing. This study demonstrated education did affect some values; however these were not necessarily values associated with traditional nursing, such as caring, honesty, and responsibility.

Thurston, Flood, Shupe, and Gerald (1989) used the Rokeach Value Survey and a second survey based on the American Association of Colleges of Nursing's seven essential values to identify the values held by faculty and new baccalaureate nursing students. The faculty completed both instruments while the students completed only the Rokeach. The faculty ranked integrity as the top American Association of Colleges of Nursing's value followed by honesty and caring. This study showed faculty and student values are more in harmony than not. It validates the findings of O'Neil (1973) and Williams (1978). A summary of these studies indicates that the typical nursing student enters professional education holding the values of religion, honesty and altruism.

Most recently, Rassin (2008) surveyed Israeli nurses and found the instrumental values of honesty, responsibility and intelligence were rated as the most important personal values. Altruism and confidentiality did not rank highly. This does represent a change in personal values of nursing students when compared with O'Neill (1973) and Williams (1978).

Professional values. Professional values in nursing were first reported in the nursing literature by Schank and Weis (1989). In this study, nursing students, registered nurses (one year after graduation) and experienced nurses (five years beyond graduation) provided demographic information, and identified their

professional values. Nursing students and experienced nurses identified human dignity, responsibility, and accountability as the most important values. Nurses at one year after graduation identified the same values as nursing students and nurses with five years experience but in inverse order (accountability, responsibility and human dignity). Neither nursing students nor experienced nurses consistently identified values related to economic welfare (conditions of employment) or to community health. Because these values are generally associated with full professional socialization, the results from Schank and Weis (1989) suggested that work experience alone does not lead to complete professional socialization of nurses.

Kelly's studies of British and American nursing students (1991, 1992) found similar professional values between the groups. As examples of their values, British students identified "respect for the patient" and "caring about the little things", defined as spending unrushed time on back rubs and other acts of caring (Kelly, 1991, p. 870). The American students identified "respect for patients" and "caring" as primary values. Like their British counterparts American nursing students described caring as "doing the little things" (Kelly, 1992, p. 13).

A descriptive study of professional values as measured by the Nurses Professional Values Scale (Martin, Yarbrough, & Alfred, 2003) found no significant differences between values held by 1,450 associate degree nursing students and baccalaureate nursing students from all nursing programs in Texas. Ethnicity was an apparent factor, however, and was found to be related to significant differences on the three sub-scales that measured dignity, client

advocacy, and community/global health concerns. Asian/Pacific Islanders scored lower than the other student groups (Caucasians, African Americans, Hispanics, and Native Americans) on the human dignity subscale, and lower than all the other groups except Native Americans on safeguarding the patient and the public. Caucasian students scored lower than African-American and Hispanic students on collaboration to meet public health needs.

As with personal values, other studies highlighted interest in identifying the professional values held by nursing faculty (Eddy, 1994; Elfrink, 1991). Initially researchers were interested in faculty opinion on the importance of the *American Association of Colleges of Nursing's Essential Values* for nursing student education. Although faculty deemed values training as important, most respondents did not include values training in their formal education plans (Elfrink & Lutz, 1991). Further, when surveyed, faculty identified equality, human dignity and freedom as important essential values (Eddy, Elfrink, Weis & Schank, 1994).

In a comparative study of British and American nursing faculty, Weis and Schank (2000) used the Nurses Professional Values Scale (based on the ANA *Code of Ethics*) to identify comparable professional values. They found British nursing faculty were more likely to participate in research, as well as to use the results of research in their practice. They were also more likely to participate in promotion of British public health issues. This would suggest that British nurses had incorporated professional values more completely than did their American counter parts.

Accountability

Accountability is an integral characteristic that all health professionals must demonstrate. Health care literature about accountability contains topics that include concern for the confidentiality of the electronic medical record (Myers, 2008) and actualizing accountability through shared governance, which is decentralized decision making with shared ownership and accountability (Moore, 2007). Outside healthcare, accountability is of interest to many disciplines; however, there have been few studies published. Rather, the focus is on which individual or group is responsible for accomplishing a task or for overseeing a program. One example of current accountability literature can be found in the area of education. State governmental agencies in Colorado (2008) and Texas (2008) are concerned with educational accountability in the implementation of the *No Child Left Behind* legislation. Additional concerns regarding accountability in education include balancing public, academic, and market demand (Burke, 2005); mentoring new teachers (Steiney, 2008); and fostering professional development (Moscinski, 2008) and accountability to students (Glicker, 2007; O'Sullivan, 2008; Tilley, 2008). Accountability as a concept in leadership literature is used for addressing accountability under stress (Bar-Joseph, 2008) and for increasing accountability in both employees (Prosen, 2007) and self (Gusky, 2007). Interest in accountability can also be found in public policy reports (Douglas, 2008; Freidman, 2008; Smith, 2000).

In nursing, accountability is most often focused on the patient safety movement, with emphasis on error reduction and quality improvement. This

movement facilitated a change in the focus of accountability for error, moving from identification of the individual who made the error to an examination of the process leading to the error (Sharpe, 2004). The literature related to patient safety and accountability contains many references to the process of Failure Mode Effects Analysis, defined as a “systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures in order to identify the parts of the process most in need of change” (Institute for Healthcare Improvement, 2008). Hospitals accredited by the Joint Commission have adopted this proactive process for error reduction (Joint Commission, 2008). However, this model does not address individual professional accountability.

Emanuel and Emanuel (1996) offered a model for accountability defined as “procedures and processes by which one party provides a justification and is held responsible for its actions by another party that has an interest in the actions” (p. 230). Three models of health care accountability are delineated as follows: (a) professional, (b) economic, and (c) political. The professional model guides the physician-patient relationship; while the political model is for the managed care arena. A combined political and economic model mediates the relationship between managed care and the employers who purchase those services. This framework, although purported for health care, is heavily medically oriented and therefore not a good fit for nursing.

A review of the nursing literature for a nursing framework for accountability found that nurses agree that accountability is fundamental to nursing practice

(Rowe, 2000). Others interchange the terms *responsibility* and *accountability* (Jormsri, 2005; Maze, 2005; Memarian, 2007).

Walsh (1997) advocated for differentiating the terms *responsibility* and *accountability*. Walsh defined accountability as "being able to give an explanation of and justification for one's actions; responsibility is carrying out instructions accurately and in the allotted time frame" (p.40). Berlandi (2002) also differentiated between accountability and responsibility, defining accountability as "being answerable and culpable for outcomes and responsibility as being answerable for one's conduct and performance" (p.1094).

Walsh (1997) explained that a registered nurse in the United Kingdom is accountable to the United Kingdom Central Council for Nursing (UKCC), the patient and to self. In the United Kingdom, the UKCC is both the registering body and professional organization for registered nurses. In the United States, the counterpart to the UKCC is the State Board of Nursing in the state in which the registered nurse is licensed. The registered nurse is accountable to the state board in which she or he is licensed. Additionally, the American Nurses Association (ANA), the professional association for registered nurses in the United States developed and promulgates the *Code of Ethics* (2001). This code represents the profession's non-negotiable ethical standard and outlines the ethical obligations of the registered nurse. These obligations include the accountability and duties of everyone who enters the profession. Furthermore, the *Code of Ethics* describes the commitment of nursing to society (Hook & White, 2003).

A discussion about accountability and a code of ethics would not be complete without a brief discussion about ethics. Ethics is a method for understanding and examining the moral life. Ethics provides a way of dealing with the basic questions of meaning and value. There are both philosophic and theological aspects to ethics (Beauchamp & Childress, 2008; Veatch, 1989). Ethics are normative and non-normative. Normative ethics are concerned with what is generally accepted as moral behavior and why the behavior is accepted as normal. Practical or applied ethics is an attempt to use normative principles to solve practical problems. There are two types of non-normative ethics. The first type of non-normative ethics is descriptive and uses scientific codes to study moral codes and beliefs. Examples would be the anthropologist or sociologist who studies which moral norms are expressed in professional practice and professional codes. The second type is meta-ethics, which analyze the language, concepts and methods of reasoning in ethics. Non-normative ethics try to establish what *is* the case, not what ethically *ought* to be the case, which is called normative ethics (Beauchamp & Childress).

According to the United Nations ([UN], 1948), morality refers to norms about what is right or wrong in human behavior and interaction. Morality encompasses moral principles, rules, rights, and virtues that are generally accepted norms across all societies. Individuals grow up recognizing and following these norms; if individuals do not follow expected norms, there are consequences. The societal norms for humans are delineated in the *United*

Nations Declaration of Human Rights signed in 1948. These human rights recognize the individual's right to life, liberty, and security of person (UN).

The earliest reference to ethics in nursing was an article comparing ethics and etiquette. "Ethics refers to character as etiquette does to manners" (Perry, 1907, p. 451). Perry identified ethical qualities of the nurse as "obedience, truthfulness, trustworthiness, neatness and punctuality" (p. 481). Levine (1977) wrote that nurses need to willingly assume ethical responsibility in every dimension of nursing practice.

There has been discussion in the nursing literature (Curtain, 1980; Yarling & McElmurry, 1986) opining that nurses who work in hospital settings are not free to be moral or ethical; although they have freedom of will, there is no freedom of action. Action is necessary to assume the ethical responsibility advocated by Levine (1977). According to Curtain (1980) and Yarling and McElmurry (1986) this lack of freedom to act is rooted in the bureaucratic milieu of the hospital, the nurse's role in that bureaucracy, the strength of nursing leadership in the system, sexism, and paternalism. The bureaucratic system removes the nurse's ability to make nursing decisions about nursing practice. Bishop and Scudder (1987) countered that notion of lack of freedom or autonomy in the bureaucratic system and suggested that teamwork among the physician, nurse, patient, family, and hospital meet the patients' needs. They argued that the entire team is necessary to morally meet patients' needs; it would not be a good situation for everyone to be working autonomously. Ketefian (1985) studied professional and bureaucratic

role conception and moral behavior among nurses and found that role conception did influence moral behavior.

Historically the ANA has recognized a need to provide a framework to assist registered nurses to make moral and ethical decisions (Twomey, 1989). The *Code of Ethics* (ANA, 2001) recognized accountability as an essential behavior and expectation for all nurses. Accountability is defined as "being answerable to oneself and others for one's own actions" (p. 16). Accountability is further described as being grounded in the moral principles of fidelity and the respect for the dignity, worth and self-determination of all patients. Beauchamp and Childress (2008) identified fidelity as the fundamental ethical principle from which all other principles can be derived. The obligation of fidelity or promise keeping is rooted in respect for autonomy and utility. Most obligations of positive beneficence in health care rest on fidelity-generating contracts and role relations (Beauchamp & Childress).

In the same code statement as accountability the ANA (2001) *Code of Ethics* also addressed responsibility. Responsibility is the accountability and liability associated with the implementation of a particular role. The nurse is responsible and accountable for individual nursing practice and the appropriate delegation of tasks to deliver optimum nursing care to patients.

Nursing practice includes direct care activities, acts of delegation, and other responsibilities such as teaching, research and administration. In all nursing activities, the nurse retains accountability and responsibility for the quality of nursing practice and for conformity with standards of care (p 16).

In delivering care, the nurse is accountable for determining his or her own ability to implement the care safely and competently. If the care required by the patient is beyond the competence of the nurse he or she must consult someone who is competent and can provide instruction on the optimum way to meet the patient's needs. When delegating tasks of patient care, the nurse is accountable not only for assessing the competence of the individual to whom he/she is delegating but also for monitoring the individual's activities and evaluating the quality of the care provided. It is not permissible for the nurse to delegate the responsibilities of assessment or evaluation (ANA, 2001).

The National Council of State Boards of Nursing (NCSBN, 2007), an organization through which boards of nursing discuss and act on matters of mutual interest and concern, recognizes accountability as a central tenant of nursing practice. In the *Principles and Premises of the National Council of State Boards of Nursing* website, accountability is described as nurses' recognition of their limitations, placing themselves in settings and roles that allow them to practice safely and understanding the need to maintain competence through life long learning. The Council further states that the nurse is responsible and accountable for exhibiting ethical behavior, assuring that client welfare prevails, practicing within the legal limits established for practice, and seeking professional education based on assessed needs.

This study was developed around the integrity of the medical record and the assumption of truth in documentation in the record. Therefore a search was conducted using medical record, falsification and accountability as search

terms'no studies were found that looked at falsification of medical records. However, according to the NCSBN, it is misconduct to falsify reports, client documents, agency records or other essential health documents. The *Code of Ethics for Nurses* statement five refers to maintenance of integrity and warns against falsification of the medical record.

Summary

The focus on patient safety through decreasing errors has changed the hospital environment. By the nature of their responsibilities, nurses play an integral role in creating a safe environment for patients who are hospitalized. Although the investigation of error currently focuses on processes and not on individuals, the registered nurses' professional *Code of Ethics* requires individual accountability for decisions and actions regarding patient care. Registered nurses face the challenge of more stringent policies designed to create a safe patient environment and, at the same time, they care for patients with very complex needs. The potential for conflict between an employer's expectations and the professional values held by the registered nurse is great. When this situation becomes untenable, some registered nurses may misrepresent their actions. Consideration must be given to reconcile the differences between employers' expectations as defined in policies and procedures and nursing's *Code of Ethics*.

Misrepresentation of actions by registered nurses has implications for patient safety. If the registered nurse faces conflict between what the employer expected and what actually happened, the registered nurse might falsify the

record, thus meeting employer expectations but violating their state board of nursing's expectations and the *Code of Ethics*. Additionally a falsified medical record does not present an accurate picture of the patient's medical response and treatment, which has implications for the patient's safety. It would be helpful for hospitals to know if registered nurses would demonstrate professional values when faced with conflict with patient care. A review of the literature revealed descriptive data related to professional values held by registered nurses but no studies that informed whether or not registered nurses would act in a professional, accountable manner when faced with patient care situations that put them in conflict with hospital policy.

Chapter Three

Methods

Research Design

This study used a descriptive, non-experimental research design. Data were collected and analyzed regarding each participant's ethical ideology, professional values and intention to act accountably. Ethical ideology was modeled after research using the Ethical Position Questionnaire (Forsyth, 1981). Ethical ideology is based on relativism and idealism. Relativism and idealism can be further divided into high and low thus forming four groups: (a) absolutists, (b) exceptionists, (c) subjectivists and (d) situationists. The participants were classified according to their self-described ethical ideology and categorized as belonging to one of these four groups. Data from the identification of ethical ideology were then analyzed to determine their effect on professional values and intention to act accountably.

Ethical Considerations

Exempted approval was sought and granted by both the University of South Florida (USF) Institutional Review Board (IRB) and the health care system in which the study was conducted. Completion and return of the survey questionnaire implied voluntary consent to participate in the study. Confidentiality of the participants was protected, as no identifying data were collected. Data were reported in aggregate format and no information was provided to participants' employers.

There were no anticipated physical, psychological, or financial risks for the participants who participated in the study. No identifying data were collected so it was impossible for the investigator to identify the participant. The investigator, who is employed in a non-managerial role in the health system used in the study, provided a contact number in case the participants had any concerns about the study.

Sample and Sampling Procedure

The participants for this study were registered nurses employed in a non-profit health system comprised of four hospitals, all of which were situated on the west central coast of Florida. This health care system has 1100 licensed beds and employs 900 registered nurses of which 700 are in direct patient care areas where medications are administered.

Prior to data collection, a power analysis was completed. A power analysis predicts if there is a strong probability that existing effects have a chance of producing significance. Power is determined by three factors: Significance level, size of treatment effects and sample size (Polit, 1999). For this study, the alpha significance level was set at .05 and Cohen's *d* was set at .50 for a medium effect size. The power analysis set at .80 indicated a need for 64 participants in each of the four cells of the taxonomic groups for a total of 256 participants.

Procedure

Once the institutional review board approvals were obtained, the investigator contacted all 27 in-patient unit nurse managers in the health care system via email to request access to the study population of registered nurses

during their team meetings. Twenty of the 27 nurse managers responded to the request for access, and the investigator distributed the surveys to registered nurses in all 20 units. This was accomplished by the investigator visiting each of the units during scheduled meetings, providing a brief overview of the study and distributing the survey questionnaires to the registered nurse attendees. Extra surveys were left on these units for those registered nurses not in attendance when the investigator was there. The investigator also distributed surveys at council meetings attended by registered nurses and at orientations held during the data collection period of May 8 through June 15, 2007. Council meetings are a part of the shared governance structure of the patient services division.

In all instances, the participants took the surveys with them. Those who completed them returned them to the investigator via self-addressed interoffice envelopes provided by the investigator. This allowed further anonymity for the participants but raised the possibility that individuals might complete more than one survey or that non-registered nurses might have participated in the study. The potential for this over participation or non-registered nurse participation was mitigated by the fact there was no reimbursement to the participants. Thus, a potential incentive for over participation was removed.

Operational Definitions

Ethical Ideology consisted of two concepts: (a) the degree of relativism (the use of universal moral rules) and (b) idealism (the belief that good can come of all situations). These characteristics are exhibited by individuals when they

make an ethical decision (Forsyth, 1981). Ethical ideology was operationalized through the Ethical Position Questionnaire for this study.

Professional values are those values identified in the ANA *Code of Ethics with Interpretive Statements* (2001). The values express nursing's own understanding of its commitment to society. The Nurses Professional Values Scale Revised (Shank & Weis, 1989) was used to measure the professional values held by nurses or nursing students for this study.

Accountability is a professional value found in the ANA *Code of Ethics with Interpretive Statements*. It is defined as being answerable to oneself and others for one's own actions. Accountability in this study was operationalized by the Accountability Instrument. It consisted of two clinical vignettes; the participant answered three 10-point Likert-type questions after each vignette.

Instruments

Information about Subjects. The face sheet of the survey booklet contained an assurance of anonymity. Thus, no identifying data were collected. Survey completion was considered as consent to be in the study. Information about participants included the demographic data of age and gender. Additional information garnered included years as a registered nurse and years in their current position. Information about religiosity and course work in ethics during nursing education was also gathered. The information about the questionnaire can be found in Appendix A.

Ethical Position Questionnaire. The Ethical Position Questionnaire (EPQ) was developed by Forsyth (1981) to help classify individuals by their ethical

ideology. The EPQ (Appendix B) consists of 20 items formed from two 10-item scales; one scale measured idealism and the other scale measured relativism. The respondents indicated agreement or disagreement to the scaled items using a nine-point Likert-type response. A median split was performed on the relativism characteristic to set high versus low relativism; likewise, a median split was performed on the idealism characteristic to set high or low idealism. This created a two (high idealism x low idealism) by two (high relativism x low relativism) configuration. Forsyth (1980) reported the mean for the relativism scale was 6.18; the mean for idealism was 6.35. Cronbach's alpha were .73 and .80 respectively. Test-retests were .67 for idealism and .73 for relativism. In this study the alpha coefficients were .80 for both the relativism and idealism scale.

Nurses Professional Values Scale Revised. The Nurses Professional Values Scale Revised (NPVSR) developed by Weis and Shank (2005) was also administered in this study (Appendix C). The NPVSR consists of 26 items with a five-point Likert-type scale format. It is based on the 2001 Code of Ethics for Nurses. Psychometric properties for the NPVSR have been evaluated but not published. The authors of the scale provided this researcher with the psychometric properties of the Nurses Professional Values Scale (NPVS) as reported in the next paragraph (personal correspondence from Darlene Weis; October, 2005).

The Nurses Professional Values Scale is a 44-item norm referenced instrument with a five-point Likert-type scale format developed to establish the degree to which nurses embrace the tenants of the ANA *Code of Ethics*. The

participants were asked to rate the importance of value statements drawn from the 2001 *Code of Ethics*. Five judges with expertise in the ANA *Code of Ethics* provided evidence in support of content validity. The reported alpha coefficient for the 44-item NPVS was .94 with a test-retest two weeks later of .94 (Weis & Shank, 2000). Unlike the NPVS, the shortened NPVS Revised contained 26 questions with a potential score range of 26 to 130. The alpha coefficient for the NPVSR in this study was .93.

Accountability Instrument. The accountability instrument (developed by the investigator, see Appendix D) consisted of two hypothetical clinical vignettes designed to represent actual clinical situations in which the registered nurse would have the opportunity to demonstrate accountability. Prior to administration of the survey five registered nurses assessed both hypothetical clinical vignettes in the instrument for content validity. All agreed the clinical vignettes as presented in accountability instrument were realistic. They also reported time used to complete all four surveys as 8 to 11 minutes. Because the accountability instrument was investigator developed, reliability scores were calculated. The alpha coefficient for the accountability instrument was .74. This met the minimal requirements for internal consistency to be considered sufficient when performing group level comparisons (Polit, 1999).

The validity of paper and pencil profiles has been demonstrated in several studies examining clinical decision making (Fisch, Hammond, Joyce, & Reilly, 1981; Gillis, Lipkin, & Moran, 1981; Holzworth & Wills, 1999; Rothert, 1982; Smith, Gilhooly, & Walker, 2003). To assess instrument validity in this study each

participant was asked to rate on a 10-point Likert-type scale how realistic he or she found the hypothetical clinical situation that was presented.

In the first vignette of the accountability instrument, there was *not* a complication for a patient when a nurse erred and did not administer a medication at the prescribed time. In the second vignette of the accountability instrument, there was a complication for the patient presumably because a nurse erred and did not administer a medication at the prescribed time. Two vignettes with different outcomes were utilized to measure registered nurses' likelihood to act accountably in situations that have opposite outcomes from the same error. In both vignettes, as happens daily in hospitals, only the nurse knew that the medications were delivered late. The nurse had to decide which time to record on the medication administration: (a) the actual time or (b) the time dictated by hospital policy. A registered nurse who acts accountably would record the actual time of medication administration. With both vignettes the participants were asked how likely they were to record the actual time of medication administration, to complete an incident report and to notify the physician. They rated their likelihood on a 10-point Likert-type scale.

Data Analysis

The raw data were entered into an EXCEL spread sheet and then uploaded into the data manager of Statistics Package for Social Sciences (SPSS) 11.0. The explore procedure was run to identify outliers. To analyze Hypothesis 1 an analysis of variance was run using the MANOVA procedure. The dependent variable for Hypothesis 1 was the mean score on professional

values; the independent variable was ethical ideology. A Pearson's correlation and an analysis of covariance using the MANOVA procedure were run to analyze Hypothesis 2. The dependent variable for Hypothesis 2 was the score on the accountability instrument; the independent variable was ethical ideology and the covariate was professional values.

Summary

This chapter presented the study design and information about the instruments used in the study. The following chapter reports the analyzed results of the study.

Chapter Four

RESULTS

A sample of 215 registered nurses employed at a four-hospital health care system on the west coast of Florida voluntarily participated in this descriptive study. This chapter presents information about the study sample, data collection methods, procedures and data analysis. The results of the two hypotheses testing are also included.

Data Collection

Data collection took place from May 8 through June 15, 2007 after distributing the surveys at inpatient units and at council meetings at a four-hospital health care system on the west coast of Florida. There were 475 surveys distributed, and 219 were returned (46% return rate). This fell short of the proposed sample size of 256 in the power analysis. The investigator stopped at that number because all avenues for distribution of the survey had been explored and no additional surveys had been returned in more than one week. Four surveys were discarded because the Nurses Professional Values Scale Revised (NPVSR) was not completed; thus the analysis was based on 215 surveys.

Preliminary Statistics

In the remaining 215 data sets, missing data on the Ethical Position Questionnaire by using a *neither agree or disagree* response and therefore the 17 missing values were scored as a 5 on the 1 to 10 scale. There were no missing data for the Professional Values scale. The four missing data points for

the accountability instrument were replaced by mean substitution for that scale ($M = 41.36$). Next, the explore procedure was run to identify outliers.

Demographic data on the study sample are presented as frequencies and descriptive statistics in Table 3. There were 195 female and 19 male respondents. The age range was 23 to 68 years with a mean age of 44.6 years. The nurses reported a range of less than one month to 49 years experience as a registered nurse with an average of 5.16 years in their current registered nurse (RN) position. On average the sample was 45 years old, female, with either an associate or bachelors degree in nursing, 17 years of nursing experience and 5 years of employment in their current position. Seventy six percent reported having had an ethics class and 79% percent had studied the *ANA Code of Ethics* in their nursing program.

The majority of respondents were Caucasian (85%) followed by Asian Pacific (7%), Hispanic (6%) and African American (5%). This larger percentage of Asian Pacific respondents is somewhat atypical for the west coast of Florida and may have resulted from heavy recruitment in the Philippines that occurred in 2005 for that hospital setting.

Table 3

Demographic Data on Study Sample

Item	<i>n</i>	Percentage
Age		
60-69	14	6%
50-59	72	34%
40-49	56	27%
30-39	39	19%
20-29	28	14%
Total	209	100%
Ethnicity		
Caucasian	179	84%
Asian Pacific	15	7%
Hispanic	8	6%
African American	7	4%
Total	215	100%
Highest Level of Nursing Education		
Diploma	13	6%
Associate	75	34%
Baccalaureate	85	40%
Masters	42	20%
Total	215	100%

Table 3 (Continued)

<i>Item</i>	<i>n</i>	<i>Percentage</i>
Gender		
Female	195	91%
Male	19	9%
Total	214	100%
Ethics		
Ethics Course	163	76%
Studied ANA Code of Ethics	170	79%

Descriptive statistics of key variables are found in Table 4. The professional values scores for this study ranged from 74 to 130 with a mean of 108.53 (from a possible range of 26 to 130). For accountability, scores for this study ranged from 20 to 60 with a mean score of 41.36 (from a possible range of 6 to 60). Religiosity demonstrated the full range of potential scores of 1 to 10. The mean religiosity score was 5.80.

Table 4

Summary Descriptives of Continuous Variables

<i>Item</i>	<i>n</i>	<i>Mean</i>	<i>Standard Deviation</i>	<i>Minimum</i>	<i>Maximum</i>
Age	209	44.60	11.06	23	68
Professional Values	215	108.53	12.22	74	130
Accountability	215	41.36	10.71	20	60
Religiosity	215	5.80	2.28	1	10

Prior to testing Hypothesis 1 and 2, correlation coefficients (Table 5) were run to determine if variables were mutually exclusive or related. No significant relationships were found between ethical ideology and accountability. However, significant relationships were found between ethical ideology and professional values. Specifically there was a significant positive relationship between idealism and professional values and a negative non-significant relationship between relativism and professional values. This relationship was further evaluated in Hypothesis 1. A significant relationship was also found between professional values and accountability ($r = .354, p < .001$). These findings affected how Hypothesis 2 was evaluated. Age, religiosity, and years as a registered nurse were also positively correlated with accountability, and were later evaluated as covariates.

Table 5

Correlation Coefficients

	<i>Account- ability</i>	<i>Professional Values</i>	<i>Idealism</i>	<i>Relativism</i>	<i>Age</i>	<i>Religiosity</i>	<i>Years RN</i>
Accountability							
Professional Values ^a	.354**						
Idealism ^b	.108*	.115*					
Relativism ^b	-.056	-.053	.062				
Age ^a	.277**	.101	-.051	-.275**			
Religiosity ^a	.182**	.191**	.033	-.147*	.000.	.	
Years RN ^a	.207**	.100	-.094	-.121	.684	.095	

Note. ^a Pearson's r ; ^b Kendall's tau b. * Significant at .05 alpha level ** significant at .01 alpha level

A small, negative and insignificant correlation was found between relativism and accountability, while a larger negative correlation had been expected. Therefore a decision was made to examine the sub-components of relativism and idealism (absolutists, exceptionists, situationists and subjectivists) separately with accountability. Bivariate correlations between the dependent variable (accountability) and each of the key independent variables were done separately. First, bivariate correlations for the accountability scores with the four groups of ethical taxonomy were done. As seen in Table 6, these revealed that only absolutists had a significant relationship with total accountability scores. The other bivariate relationships were of negative direction and non-significant. Within the low relativism component of the ethical taxonomy, represented by both the absolutists and the exceptionists, there was a moderate and significant inverse relationship between the absolutists and exceptionists. Within the high relativism component of the ethical taxonomy, represented by the situationists and the subjectivists, there was a moderate and significant inverse relationship between the situationists and the subjectivists.

Table 6

Bivariate Correlations for Accountability by Ethical Taxonomy (N = 215)

	<i>Accountability</i>	<i>Absolutist^a</i>	<i>Exceptionist^a</i>	<i>Situationist^b</i>	<i>Subjectivist^b</i>
<i>Accountability</i>					
<i>Absolutist^a</i>	0.145*				
<i>Exceptionist^a</i>	-0.027	-0.343**			
<i>Situationist^b</i>	-0.024	-0.330**	-0.299**		
<i>Subjectivist^b</i>	-0.097	-0.369**	-0.335**	-0.322**	

Note. ^a Relativist Category ^b Idealist Category * Significant at .05 alpha level

** Significant at .01 alpha level

Prior to testing Hypothesis 1 and Hypothesis 2, reliability tests were completed on the investigator-developed accountability instrument. The instrument consisted of three questions that participants answered immediately after reading two different clinical vignettes involving a late administration of a medication. In both clinical vignettes the participant was asked how likely on a 10-point Likert-type scale they were to record the actual time of medication administration, complete an incident report, and notify the physician. The alpha coefficient for the accountability instrument was .74. Inter-item correlations were conducted among the six items (see Table 7). Additionally after each vignette was presented, the respondents were asked, on a 10-point Likert-type scale of how realistic they found the vignettes. Scores for this question could range from 2 to 20. Mean score for this study was 16.10 indicating that the respondents found the vignettes “very to extremely realistic”.

Consistency was observed in the manner in which participants responded to the three questions following each of the two vignettes (see Table 7). The correlation between the *time documented* question in each vignette was strong ($r = .94$), as was the correlation between the *call physician* question in each vignette ($r = .85$). The correlation between completing the *incident report* question in each vignette was weaker ($r = .43$). The latter results suggest that in the presence of a complication, registered nurses reacted differently than if there was not a complication. According to Polit (1999), reliabilities are best if at least .70 or above; thus, 2 out of 3 questions were above this suggested value. No reverse scoring was needed for any of the items.

Table 7

Inter-Item Reliability Coefficients

	<i>Time Document</i> ¹	<i>Call Phys</i> ¹	<i>Incident Report</i> ¹	<i>Time Document</i> ²	<i>Call Phys</i> ²	<i>Incident Report</i> ²
Time Documented ¹						
Call Physician ¹	.034					
Incident Report ¹	-.034	.774*				
Time Documented ²	.938*	.016	-.071			
Call Physician ²	-.024	.852*	.721*	-.008		
Incident Report ²	.0369	.334*	.432*	.062	.385*	

Note: ¹ Response after 1st vignette. ² Response after 2nd vignette. * Significant at .01

Hypothesis 1

Hypothesis 1 stated that registered nurses who demonstrated a low relativistic (absolutist or exceptionist) ethical ideology would score higher on a

measure of professional values than would registered nurses who demonstrated a high relativistic (situationist or subjectivist) ethical ideology. Referring to Figure 1 on page 7, recall that ethical ideology was conceptualized as having a direct effect on professional values. The high versus low relativists were targeted for this hypothesis; however all four subgroups of the ethical ideology taxonomy were included (situationists, subjectivists, exceptionists, and absolutists). This was necessary to do the MANOVA procedure.

In order to evaluate Hypothesis 1, participants first had to be classified as low relativists or high relativists and as low idealists or high idealists. The scores on the two subscales (relativism and idealism) of ethical ideology were first computed. A median split was performed to form the groups of high versus low relativists and of high versus low idealists. Relativism scores ranged from 10 to 90 with a median score of 50 ($M = 52.09$, $SD = 16.49$). Therefore, scores of 50 and below on the relativism scale were classified as low relativists; scores of 51 and above were classified as high relativists. Idealism scores ranged from 22 to 90 with a median score of 73 ($M = 70.80$, $SD = 13.87$). Therefore any scores 73 and below were considered low idealists; scores of 74 and above were classified as high idealists. Thus the two groups, relativists and idealists, were each subdivided into high or low relativists or idealists. The low relativists consisted of absolutists ($n = 59$) and exceptionists ($n = 51$). The high relativists consisted of situationists ($n = 48$) and subjectivists ($n = 51$).

Scores on the Nurses Professional Values Scale Revised were then computed. The scores ranged from 74 to 130 ($M = 108.43$, $SD = 12.16$). Table 8

illustrates the mean values of the professional values scores according to the relativism group classifications. The marginal mean for the professional value score for the low relativists ($M = 110.19$) was higher than the marginal mean for the professional value score for the high relativists ($M = 106.78$). This was in the predicted order that RNs who were low relativists would score higher on this measure of professional values than would the RNs who were high relativists. In contrast, those participants who were high idealists had higher marginal mean scores ($M = 111.37$) on professional values than did those who were low idealists ($M = 105.72$). This finding is explored further in the analysis of Hypothesis 2.

Table 8

Group and Marginal Means of Professional Values Scores by Ethical Taxonomy

	High Relativism	Low Relativism	Marginal Means
High Idealism	Situationist $N = 48$ $M = 110.23$ $SD = 12.26$	Absolutist $N = 59$ $M = 112.29$ $SD = 10.49$	111.37
Low Idealism	Subjectivist $N = 57$ $M = 103.88$ $SD = 12.64$	Exceptionist $N = 51$ $M = 107.77$ $SD = 12.09$	105.72
Marginal Means	106.78	110.19	

Next, a 2 x 2 analysis of variance was conducted using the MANOVA procedure, with relativism (high and low) and idealism (high and low) as independent variables and the Nurses Professional Values Scale Revised scores as the dependent variable. The results are illustrated in Table 9. As noted previously, examination of the marginal means for the low versus high relativists showed that the low relativists had higher marginal means than did the high relativists. The main effect of relativism on professional values was not significant ($p = .07$). Therefore Hypothesis 1 was not supported. However the main effect of idealism on professional values was significant ($p = .001$). Additionally there was no significant interaction between the independent variables ($p = .57$), meaning that relativism and idealism were independent of each other. The values for accountability were consistent across all levels of relativism and across all levels of idealism.

Table 9

Analysis of Variance of Nurses Professional Values by Ethical Ideology

<i>Source</i>	<i>df</i>	<i>MS</i>	<i>F</i>	η^2	<i>p</i>
Within Cells	211	140.80			
Relativism	1	471.89	3.35	.02	.07
Idealism	1	1578.38	11.42	.05	.001
Relativism x Idealism	1	44.62	.59	.002	.57

Hypothesis 2

Hypothesis 2 stated that absolutists are more likely to act accountably in hypothetical clinical situations than exceptionists. Exceptionists are more likely to act accountably than are subjectivists and subjectivists are more likely to act accountably than are situationists.

Recall that in Figure 1 (page 7) ethical ideology was depicted as having both a direct effect and an indirect effect on accountability. To test Hypothesis 2, several different procedures were used; first, a descriptive summary was used to analyze the ordered means of the total accountability scores by ethical taxonomy group. Then an ANCOVA using the MANOVA procedure was used to analyze the total accountability scores as the dependent variable. And finally, the accountability questions were examined individually to see if any of their effects were masked by being bundled into a composite accountability score.

Potential scores ranged from 1 to 10 on each item; the total score could range from 6 to 60 on the six-question accountability instrument. Individuals who answered at least a *very likely* and *extremely likely* (a score of 7 out of 10 possible on that item) in response to all six accountability questions and who thus scored a minimum of 42 to 60 were considered to be “accountable”. The responses of *very likely* and *extremely likely* were chosen to indicate accountability as these were the highest two categories on the scale and were above the median.

Actual accountability scores ranged from 20 to 60 with 60 being the most frequent score (frequency = 18); the mean score was 41.36 ($SD = 10.71$). There

were 103 (48%) of the respondents who scored in the range 42 to 60 on the accountability instrument and were therefore considered “accountable”.

The means and standard deviations for each of the taxonomic groups of ethical ideology on the accountability instrument are presented in Table 10. As predicted, the absolutists had higher mean accountability scores than did the exceptionists. Likewise, the exceptionists had higher mean accountability than did the subjectivists. However, contrary to prediction, the subjectivists did not have higher accountability than the situationists.

Table 10

Group and Marginal Means of Accountability Scores by Ethical Taxonomy

	High Relativism	Low Relativism	Marginal Means
High	Situationist	Absolutist	
Idealism	<i>N</i> = 48	<i>N</i> = 59	
	<i>M</i> = 40.68	<i>M</i> = 44.29	42.67
	<i>SD</i> = 10.34	<i>SD</i> = 10.82	
Low	Subjectivist	Exceptionist	
Idealism	<i>N</i> = 57	<i>N</i> = 51	
	<i>M</i> = 39.59	<i>M</i> = 40.60	40.07
	<i>SD</i> = 10.55	<i>SD</i> = 10.75	
Marginal	40.09	42.58	
Means			

The next task was to complete the ANCOVA with the four taxonomic groups of the ethical ideology (absolutists, exceptionists, situationists, and subjectivists) as the independent variable, accountability as the independent variable and professional values as the covariate for this ANCOVA procedure. The ANCOVA helped clarify the indirect and direct effects of ethical ideology on accountability for Figure 1. Results of the analysis of covariance are found in Table 11.

Table 11

Analysis of Covariance of Accountability by Ethical Ideology with Professional Values as Covariate

<i>Source</i>	<i>df</i>	<i>MS</i>	<i>F</i>	η^2	<i>p</i>
Within Cells	210	100.95			
Professional Values ^a	1	2617.95	25.93	.11	.000
Idealism ^b	1	30.36	.30	.001	.584
Relativism ^b	1	107.27	1.06	.01	.304
Idealism X Relativism	1	131.84	1.30	.01	.255

Note. ^a Covariate variable = Professional Values ^b Independent variables

After controlling for in the effect of Professional Values, the adjusted means (Table 12) were in the predicted order; however, since the test of significance for the differences among those means was still not significant, Hypothesis 2 was still not supported completely.

Table 12

Adjusted Group and Marginal Means of Accountability Scores by Ethical Ideology with Professional Values as Covariate

	High Relativism	Low Relativism	Marginal Means
High	Situationist	Absolutist	
Idealism	<i>N</i> = 48	<i>N</i> = 59	
	<i>M</i> = 40.18	<i>M</i> = 43.18	41.83
Low	Subjectivist	Exceptionist	
Idealism	<i>N</i> = 57	<i>N</i> = 51	
	<i>M</i> = 40.97	<i>M</i> = 40.83	40.91
Marginal Means	40.61	42.09	

After the original descriptive summary and ANCOVA were completed a decision was made to examine the data for a monotonic trend, which is a less stringent measure of detecting differences among means (Abelson & Tukey, (1963). The monotonic trend would indicate whether or not there was an increasing order for all four ethical ideologies when compared to the total accountability scores. The analysis for monotonic trend was completed on the analysis of covariance with the accountability scores. The results of the analysis for monotonic trend can be found in Table 13. There was no support for a monotonic trend.

Table 13

Monotonic Trend Analysis Accountability Instrument

<i>Source</i>	<i>df</i>	<i>SS_{MT}</i>	<i>MS_{error}</i>	<i>F</i>	<i>p</i>
ANCOVA	1, 210	8.116	105.57	.076	>.05

Due to the significant correlation among accountability, religion and age (see Table 5) and their potential to be confounding variables, an analysis of covariance using the MANOVA procedure was performed. Accountability was the dependent variable, ethical taxonomy was the independent variable and age and religion were covariates. After controlling for age and religion no significant differences among means for accountability by ethical taxonomy were found.

Finally, after completing the descriptive summaries, the ANCOVA procedures and the monotonic trend analysis on the entire accountability total score, the decision was made to separately analyze each of the three questions of the accountability instrument across the two vignettes. This was done in case the individual differences were masked by using a composite total score for accountability.

To complete the analysis of Hypothesis 2, a series of analyses were performed. The analysis of their ordered means was done by individual question, one at a time, next an analysis of covariance using the MANOVA procedure was performed on *each* of the individual questions of the accountability instrument, using the NPVSR as the covariate and the ethical ideology group as the independent variable.

Scores on the individual questions for the two vignettes of the accountability instrument may range from 2 to 20. As in the case when considering the entire accountability instrument, individuals who answered *very likely* and *extremely likely* in response to the individual accountability questions and who scored a minimum of 14 to 20 were considered to be “accountable”. The responses of *very likely* and *extremely likely* were chosen to indicate accountability as these were the highest two categories on the scale and were above the median. The descriptive summary is given first, followed by the ANCOVA for each of the three accountability domains.

First, the accountability score for reporting the correct time of medication administration was analyzed (Question 1). Respondents’ accountability scores for time of administration across both vignettes ranged from 2 to 20 with 20 being the most frequent score (frequency = 111); the mean score was 17.59 ($SD = 4.12$). There were 201 (93%) of the respondents who scored in the range 14 to 20 on Question 1 of the accountability instrument and were therefore considered “accountable” regarding documenting the actual time of administration.

Respondents’ accountability scores for Question 2 (calling the physician) across both vignettes ranged from 2 to 20 with 20 being the most frequent score (frequency = 31). There were 80 (37%) of the respondents who scored in the 14 to 20 range on Question 2 of the accountability instrument and were therefore considered “accountable” with regard to calling the physician.

Accountability scores for Question 3 (completing an incident report) ranged from 2 to 20 with 20 being the most frequent score (frequency = 26).

There were 89 (41%) respondents who scored in the 14 to 20 range on Question 3 of the accountability instrument and were therefore considered “accountable” with regard to completing an incident report. Thus for the descriptive summary for each individual accountability question, 93% of the nurses reported being accountable for documenting the correct time of medication administration, while only 34% reported calling the physician and 41% completing an incident report.

The ordered means resulting from the ANCOVA can be found in Table 14. As illustrated in Table 14 there are two unique orders of means among the three possible orders. With *time of administration* the order of means was as predicted; absolutists scored higher than exceptionists; exceptionists scored higher than subjectivists and subjectivists scored higher than situationists. For the two remaining items in Table 14, *calling the physician* and *completing an incident report*, the orders of means were identical; however, these orders were not as predicted.

Table 14

Means of Individual Questions of Accountability Instrument by Ethical Ideology with Professional Values as a Covariate

		<i>High</i>	<i>Low Relativism</i>
		<i>Relativism</i>	
Question 1	High Idealism	Situationist	Absolutist
(Record Time)		<i>N</i> = 48	<i>N</i> = 59
		<i>M</i> = 17.19	<i>M</i> = 18.09
		<i>SD</i> = 4.53	<i>SD</i> = 3.95
	Low Idealism	Subjectivist	Exceptionist
		<i>N</i> = 57	<i>N</i> = 51
		<i>M</i> = 17.46	<i>M</i> = 17.55
		<i>SD</i> = 3.46	<i>SD</i> = 4.61
Question 2	High Idealism	Situationist	Absolutist
(Call Physician)		<i>N</i> = 48	<i>N</i> = 59
		<i>M</i> = 11.02	<i>M</i> = 12.31
		<i>SD</i> = 5.74	<i>SD</i> = 6.30
	Low Idealism	Subjectivist	Exceptionist
		<i>N</i> = 57	<i>N</i> = 51
		<i>M</i> = 10.32	<i>M</i> = 10.57
		<i>SD</i> = 5.81	<i>SD</i> = 6.14

Table 14 (Continued)

		<i>High</i>	<i>Low</i>
		<i>Relativism</i>	<i>Relativism</i>
Question 3	High Idealism	Situationist	Absolutist
(Complete Report)		<i>N</i> = 48	<i>N</i> = 59
		<i>M</i> = 12.49	<i>M</i> = 13.95
		<i>SD</i> = 4.69	<i>SD</i> = 4.35
	Low Idealism	Subjectivist	Exceptionist
		<i>N</i> = 57	<i>N</i> = 51
		<i>M</i> = 11.82	<i>M</i> = 12.45
		<i>SD</i> = 4.72	<i>SD</i> = 5.21

Finally, the individual questions were analyzed by ANCOVA. As seen in Table 15, there were not any significant effects for the independent variable (ideology group) after controlling for the main effect of the covariate (Nurses Professional Values Scale Revised). The potential effect of the covariate *nurses' professional values* will be explored in Chapter 5.

Table 15

Analysis of Covariance of Individual Accountability Questions by Ethical Ideology with Professional Values as Covariate

<i>Source</i>	<i>df</i>	<i>MS</i>	<i>F</i>	η^2	<i>p</i>
Question 1 (Record Time) ^a					
Within Cells	210	17.14			
Professional Values	1	1.75	.10	.00048	.750
Idealism	1	1.56	.09	.00043	.763
Relativism	1	14.09	.82	.00390	.366
Idealism X Relativism	1	8.32	.49	.00231	.487
Question 2 (Call Physician) ^b					
Within Cells	210	32.83			
Professional Values	1	732.19	22.30	.09601	.000
Idealism	1	6.81	.21	.00099	.649
Relativism	1	4.71	.14	.00068	.705
Idealism X Relativism	1	23.21	.71	.00336	.401
Question 3 (Complete Report) ^c					
Within Cells	210	19.67			
Professional Values	1	608.95	30.96	.12850	.000
Idealism	1	4.85	.25	.00117	.620
Relativism	1	20.17	1.03	.00486	.312
Idealism X Relativism	1	15.61	.79	.00376	.374

Follow up Significant Analyses

Hypothesis 1. After noting the significant relationship between religiosity and professional values, a decision was made to further explore the effect of idealism and relativism on professional values while controlling for religiosity. An

analysis of covariance using a MANOVA procedure was performed with relativism and idealism as the independent variables, religiosity as the covariate and professional values as the dependent variable.

Table 16

Group Means and Marginal Means for Professional Values by Ethical Ideology with Religiosity as Covariate

	High Relativism	Low Relativism	Marginal Means
High Idealism	Situationist <i>N</i> = 48 <i>M</i> = 110.23 <i>SD</i> = 12.26	Absolutist <i>N</i> = 59 <i>M</i> = 112.29 <i>SD</i> = 10.49	111.87
Low Idealism	Subjectivist <i>N</i> = 57 <i>M</i> = 103.88 <i>SD</i> = 12.64	Exceptionist <i>N</i> = 51 <i>M</i> = 107.77 <i>SD</i> = 12.09	105.57
Marginal Means	106.70	110.62	

Table 16 illustrates the mean values of the professional values scores according to the taxonomic group classifications while controlling for religiosity. The marginal mean for the professional value score for the low relativists (*M* = 110.62) was higher than the marginal mean for the professional value score for the high relativists (*M* = 106.70). The results were in the hypothesized direction

that RNs who were low relativists would score higher on a measure of professional values than would the RNs who were high relativists. These marginal means were corroborated by the results from the MANOVA procedure. In contrast, those participants who were high idealists had higher marginal mean scores ($M = 111.37$) on professional values than did those who were low idealists ($M = 105.72$).

Next, a 2 x 2 analysis of variance was conducted using the MANOVA procedure, with relativism and idealism as independent variables, the Nurses Professional Values Scale Revised scores as the dependent variable and religiosity as the covariate. The results are illustrated on Table 17. The main effect of relativism on professional values was not significant ($p = .12$). However the main effect of idealism on professional values was significant ($p = .002$). There was no interaction between the independent variables.

Table 17

Analysis of Covariance of Professional Values by Ethical Ideology with Religiosity as Covariate

Source	df	MS	F	η^2	p
Within Cells	210	138.11			
Religiosity	1	704.46	5.10	.02	.03
Relativism	1	340.03	2.46	.01	.12
Idealism	1	1329.45	9.63	.04	.002
Relativism x Idealism	1	21.51	0.16	.001	.69

This section explored the main effect of relativism and idealism on professional values after controlling for the effect of religiosity. The marginal means for low relativists were in the predicted direction; however the test of significance revealed it was idealism and not relativism that had a significant effect on professional values when controlling for religiosity.

Hypothesis 2. The strong correlation among accountability, idealism, age ($r = .28, p < .01$), religiosity ($r = .18, p < .01$) and years as a registered nurse ($r = .217, p < .01$) prompted further analysis in follow-up testing for Hypothesis 2. Therefore an analysis of covariance on each question of the accountability instrument using the MANOVA procedure was run with age, religiosity and years as a registered nurse as covariates, accountability as the dependent variable and ethical ideology (relativism, idealism) as the independent variable.

Tables 18 to 20 show the marginal means of the ethical taxonomy groups for each of the three questions of the accountability instrument with age as the

covariate. For Question 1 the means were in the following order: Absolutists, exceptionists, subjectivists and finally situationists. For Questions 2 and 3, the descending order was different than for Question 1; absolutists scored highest, followed by situationists, exceptionists and then subjectivists.

Table 18

Means and Marginal Means for Accountability Question 1 by Relativism/Idealism after Controlling for Age

Question 1 (Record Time) ^a	High Relativism	Low Relativism	Marginal Means
High Idealism	Situationist <i>N</i> = 47 <i>M</i> = 17.13 <i>SD</i> = 4.56	Absolutist <i>N</i> = 58 <i>M</i> = 18.053 <i>SD</i> = 3.98	17.64
Low Idealism	Subjectivist <i>N</i> = 55 <i>M</i> = 17.36 <i>SD</i> = 3.49	Exceptionist <i>N</i> = 49 <i>M</i> = 17.49 <i>SD</i> = 4.69	17.42
Marginal Means	17.26	17.80	

Table 19

Means and Marginal Means for Accountability Question 2 by Relativism/Idealism after Controlling for Age

Question 2	High Relativism	Low Relativism	Marginal Means
(Call Physician) ^a			
High Idealism	Situationist	Absolutist	
	<i>N</i> = 47	<i>N</i> = 58	
	<i>M</i> = 11.00	<i>M</i> = 12.31	11.72
	<i>SD</i> = 5.80	<i>SD</i> = 6.36	
Low Idealism	Subjectivist	Exceptionist	
	<i>N</i> = 55	<i>N</i> = 49	
	<i>M</i> = 10.06	<i>M</i> = 10.43	10.23
	<i>SD</i> = 5.75	<i>SD</i> = 6.21	
Marginal Means	10.49	11.45	

Table 20

Means and Marginal Means for Accountability Question 3 by Relativism/Idealism after Controlling for Age

Question 3	High Relativism	Low Relativism	Marginal Means
(Complete Form)			
High Idealism	Situationist	Absolutist	
	<i>N</i> = 47	<i>N</i> = 58	
	<i>M</i> = 12.70	<i>M</i> = 14.02	13.43
	<i>SD</i> = 4.74	<i>SD</i> = 4.36	
Low Idealism	Subjectivist	Exceptionist	
	<i>N</i> = 55	<i>N</i> = 49	
	<i>M</i> = 11.61	<i>M</i> = 12.47	11.96
	<i>SD</i> = 4.68	<i>SD</i> = 5.06	
Marginal Means	12.11	13.31	12.70

^a Question 3 asks "how likely are you to complete an incident report?"

Although the order of means for Question 1 (Table 18) was as predicted, the order of means for Question 2 (Table 19) and Question 3 (Table 20) were not as predicted. Instead, the absolutists scored highest, followed by the situationists, the exceptionists, and then the subjectivists. The tests of significance for each of the three questions of the accountability instrument while controlling for age are shown in Table 21. Even though relativism did not produce a significant main effect for any of the three questions, idealism did produce a

significant main effect on the Question 3, which was the decision to complete an incident report ($F_{[1, 204]} = 4.83, p = .03$).

Table 21

Individual Accountability Questions by Relativism/Idealism with Age as Covariate

Question 1 (Record Time)	<i>df</i>	<i>MS</i>	<i>F</i>	η^2	<i>p</i>
Within Cells	204	17.39			
Age	1	21.39	1.23	.006	.269
Relativism	1	24.41	1.40	.007	.238
Idealism	1	.98	0.06	.000	.813
Relativism X Idealism	1	6.69	0.38	.002	.536
Question 2 (Call Physician)	<i>df</i>	<i>MS</i>	<i>F</i>	η^2	<i>p</i>
Within Cells	204	33.50			
Age	1	650.77	19.42	.087	.000
Relativism	1	2.11	0.6	.000	.802
Idealism	1	125.21	3.74	.018	.055
Relativism X Idealism	1	24.21	0.72	.004	.396
Question 3 (Complete Incident Report)	<i>df</i>	<i>MS</i>	<i>F</i>	η^2	<i>p</i>
Within Cells	204	20.20			
Age	1	385.47	19.08	.086	.000
Relativism	1	5.38	0.27	.001	.606
Idealism	1	97.66	4.83	.023	.029
Relativism X Idealism	1	10.46	6.87	.003	.473

The analysis of covariance using the MANOVA procedure was completed with ethical ideology as the independent variable, the individual questions of the accountability instrument as the dependent variables, and religiosity and years of experience as a registered nurse as the covariates. This analysis produced no significant main effects.

This section explored each of the three accountability questions to establish the main effects of relativism and idealism on accountability when controlling for age, religiosity and years of experience as a registered nurse. When controlling for age, Question 1 did produce the predicted order of means; however relativism did not have a significant main effect on the taxonomic group order. There was no significant main effect for Question 2. For Question 3 (completing an incident report), idealism did have a significant main effect on taxonomic order. Religiosity and years of experience as a registered nurse had no significant main effect on any of the questions on the accountability instrument.

Summary

The data were analyzed to test two hypotheses:

1. Registered nurses who demonstrate a low relativistic (absolutist or exceptionist) ethical ideology would score higher on a measure of professional values than would registered nurses who demonstrate a high relativistic (situationist or subjectivist) ethical ideology.
2. Absolutists are more likely to act accountably in hypothetical clinical situations than exceptionists. Exceptionists are more likely to act

accountably than are subjectivists and subjectivists are more likely to act accountably than are situationists.

For Hypothesis 1, the investigator found that although the means for low relativists were in the predicted direction, Hypothesis 1 was not supported as there was not a significant difference between the marginal means of low relativists and high relativists. In contrast, idealism did have a significant main effect on a measure of professional values. Additionally there was no support for Hypothesis 2. In Hypothesis 2, the order of taxonomic means (absolutist, exceptionist, subjectivist and situationist) on the accountability instrument was not as predicted. Each question on the accountability instrument was examined separately in case the individual differences among the three questions were masked by using a composite total score for accountability, While time of administration did produce the predicted order of taxonomic means, ethical ideology did not have a significant effect on documenting the actual time of medication administration ($p = .68$). However, when controlling for the effect of age, ethical ideology did have a significant effect on completing an incident report ($p = .03$). However the significant main effect was for idealism and not the hypothesized relativism. After controlling for religiosity and years of experience as a registered nurse, ethical ideology had no significant main effect on this measure of accountability.

Lastly, once the linkage between ethical ideology and nurses' professional values was established, the investigator decided to explore Nurses Professional Values with the components of ethical ideology (relativism and idealism) and with

religiosity as a covariate. This was done because religiosity had a significant correlation with a measure of professional values ($r = .19, p = .01$). The results with the covariates were similar to those results of the original analysis without any covariates; a significant main effect of idealism was found even when religiosity was controlled.

In summary, two hypotheses were tested. In the first hypothesis, a link was established between nurses' professional values and ethical ideology; however the hypothesized effect was not significant. Therefore there was no support for Hypothesis 1. In the second hypothesis, the ordering of the taxonomic means was demonstrated to be different from that which was hypothesized and there were no significant differences in accountability scores by taxonomic groups. The correlation between ethical taxonomy and accountability prompted the researcher to do additional analyses on the differences of group means (relativism or idealism) in accountability scores. When age was controlled, ethical ideology (specifically idealism) did have a significant effect on completion of an incident report. Controlling for religiosity and years of experience as a registered nurse revealed no significant effect of ethical ideology on any of the questions on the accountability instrument. Chapter 5 presents the limitations, implications for nursing and recommendations for future research that emerged from this research.

Chapter Five

Discussion

Introduction

This study was undertaken to identify the influence of ethical ideology and professional values on registered nurses' intentions to act accountably. The study was important because there is limited research on how registered nurses demonstrate the values they purport to hold. Study results have shown that nurses may misrepresent their actions when they feel a conflict between their values and the requirements of their work environment (Grover, 1993a, 1993b). This investigator wished to determine if ethical ideology and professional values would influence nurses' reports of how they would respond to two hypothetical, yet realistic, clinical vignettes. In the clinical vignettes, the registered nurses should have reported they would document the actual administration time when a medication was given late. This would have put the registered nurse in conflict with facility policy. These two vignettes created a moral dilemma for the nurses by forcing them to choose between documenting the actual time versus the scheduled time of medication administration. Whether to uphold professional universal moral principles are the types of decisions nurses often face, and this research highlighted the discrepancy between the *Code of Ethics* and the moral conduct of nurses.

This chapter focuses on the interpretation, limitations and implications related to the results obtained from this study. Recommendations for future research are presented.

Discussion

Professional values and accountability were each major components of the model. These two factors will be discussed separately, starting with professional values.

This study evaluated a relationship between a registered nurse's ethical ideology and a measure of professional values. Registered nurses who were classified as low relativists (who thus use universal moral principles for decision making) scored higher on a measure of professional values than did highly relativistic registered nurses (who do not use universal moral principles for decision making). However the difference between the scores of high relativists and low relativists was not significant. In contrast the effect of idealism did have a significant effect on a measure of professional values. This indicated that registered nurses do not necessarily make decisions based on ethical principles but rather on the concept of how much good can be realized from the decision.

Ketefian (1982b) found a significant direct correlation between moral reasoning and valuing moral behavior when faced with a nursing dilemma. This study builds upon Ketefian's work by correlating nurses' types of moral reasoning, defined by their ethical ideology, with their professional values.

Professional values build upon personal values developed from one's life experiences (Bjorkstrom, 2007; Horton, 2007). Personal values may include

religiosity, honesty and altruism (O'Neil, 1973; Thurston et al., 1989; Williams, 1978). Although it was not the primary focus of this research, the demographics showed that the mean score for religiosity was 5.9 on a 10-point Likert-type scale. Furthermore there was a direct correlation between religiosity and professional values. This partially supports the studies done by Horton and Bjorkstrom.

Personal values also include honesty, responsibility and intelligence (Rassin, 2008). According to the theories of moral development by Dewey (as cited by Archambault, 1964), Piaget (as cited by Ketefian, 1981a), Kohlberg (1981) and Gilligan (1977), the development of moral values is associated with maturation of age as well as maturation of cognitive knowledge. The relationship between ages, years of experience as a registered nurse and nurses' professional values was not significant. Thus, this study did not support previous findings of maturation of age or years of experience and moral development.

There were three measures of accountability in this study: (a) documentation of correct time, (b) notification of the physician, and (c) completion of an incident report. Even though the prior studies indicated that the nurses value accountability and integrity as being fundamental to their nursing practice (Rowe, 2000; Schank & Weis, 1989; Thurston, et al., 1989), actual translation of that belief into practice did not consistently happen in this study. The bridge between values and actual accountability actions needs further exploration.

Self-disclosure may have had an impact on some of the findings. The commonly held belief that medication errors are under reported (Food and Drug Administration [FDA], 2008) was supported in this study. Only 34% of respondents indicated they were *very likely* or *extremely likely* to complete an incident report after a medication error. However, despite the hospital administration of the health care system stating there is a non-punitive reporting policy already in place, the name of the individual who completes an incident report is recorded. The necessity to self-identify as the completer of the incident report may have influenced the participants' willingness to report a medication incident. The need to self-identify when calling the physician to report a medication error also may have influenced the participants' willingness to notify a physician when a medication was late.

Even though this study did indicate that a nurse's ethical ideology impacted their professional values (Hypothesis 1), this research did not support the theories of Forsyth (1980; 1981; 1985) or of Forsyth and Pope (1984) that ethical decision making is based on ethical ideology (Hypothesis 2). After controlling for nurses' professional values, there was not a significant effect on accountability added by ethical ideology.

Furthermore, despite nursing educators' values of integrity (Thurston et al., 1989) and despite congruence between educators' values and student nurses' values (Redman, 1966; Thurston & O'Neill, 1975), this study showed that after graduation, nurses may not always act accountably or with integrity. However for some of the nurses, the issue might not have been one of integrity;

instead, some of the nurses might not have even recognized that the vignettes were presenting errors. If they did not envision the vignettes as errors, they might not have seen any reason to self-disclose by reporting the incident or by calling the physician.

Significance of Findings

This is the first study to examine the effect of registered nurses' ethical ideology on professional values and their intentions to act accountably. Previous studies explored the personality traits (Bailey & Klaus, 1969; Grossack, 1957; Levitt, Lubin, & Zuckerman, 1962; Redden & Scales, 1961; Schulz, 1965; Smith, 1968; Stein, 1969), personal values (Durstan, 1964; Garvin & Boyle, 1985; May & Ilardi, 1970; O'Neill, 1973; Redman, 1966), and professional values (Eddy 1994; Eddy, Elfrink, Weis & Shank, 1994; Elfrink, 1991; Kelly, 1991, 1992; Martin, Yarbrough & Alfred, 2003; Shank & Weiss, 1989) as characteristics of registered nurses and nursing students. However, none of these previous studies attempted to link intention to act with the personality traits, personal values, or professional values that characterized nurses. In light of the current emphasis on patient safety and error prevention, and with policies and procedures requiring error reporting so that processes leading to errors may be studied, it was surprising that the literature contained no studies that supported mandatory reporting of error as a means to decrease errors. Additionally there were no studies that examined falsification of the medical record. This identified gap in the literature lead to the development of this study around the integrity of the medical record and the assumption of truth in documentation in the record.

Implications

Based on these findings, the hospital administrators in the health care system in the study should develop a definitively non-punitive error reporting system that forgoes collecting names of registered nurses who complete an incident report for a medication error (Peshek, 2004; Potylycki et al., 2006; Stump, 2000; U, 2001). The Institute on Hospital Improvement ([IHI], 2008a, 2008b, 2008c) provides examples of non-punitive policies on their website. In addition, orientation programs and classes should include information on the non-punitive environment for reporting medication errors. Time should be spent discussing the advantages of reporting late medications and other medication errors, even when there is no perceived harm to the patient.

Additionally the administrators should do a root cause analysis of the incidents to identify barriers to reporting errors. With enough information on the reasons for late medications, hospitals can change processes and eliminate some of these causes. As barriers are removed and medications are more easily delivered on time, the values conflict or moral distress that may be perceived by the registered nurses should decrease. In turn, perhaps this might decrease the numbers of RNs leaving the acute care setting.

The relationship between ethical ideology and professional values on a registered nurse's intention to act accountably lends support for schools of nursing to require course work in ethics and the *ANA Code of Ethics*. This course work should include clinical situations faced by registered nurses where the nurse must make decisions to act accountably. One suggestion is to include

vignettes where the medicine is administered within the allowable time (one hour before or up to one hour after a scheduled administration time); will the nurses report the exact time of administration or will they report the scheduled time of administration? Education might focus on the unintended consequences of not acting accountably even in the seemingly harmless scenario of giving a medication within the two hour window allowed, but not at the exact time ordered. Documenting actual administration time versus scheduled administration time remains critical to the safety of the patient even if no error occurred. Knowing that the expectations of the practice environment may conflict with the professional values learned during nursing education, schools of nursing may wish to focus on enhancing the students' strategies for coping with potential conflicts.

Recommendations for Future Research

The results of this study suggest several areas for future research in practice and education. Future studies regarding the completion of incident reports might explore the following areas: (a) barriers to completing incident reports, (b) physicians' beliefs and preferences regarding receiving error notification, (c) barriers to notifying the physician, and (d) barriers to recording the accurate time of administration. First, this study corroborated prior research that medication errors are under reported. A future study could measure the impact of targeted training for incident reporting and of implementing a non-punitive error-reporting system.

Second, although it is assumed the physician would want to know if a medication is late regardless of any apparent effect on the patient, this has not

been shown in the literature. Therefore, another line of inquiry would be to assess physicians' preferences for being notified, by what mechanisms and in what time frames.

Third, while it is hospital policy to notify the physician if an injury with apparent harm occurs, some registered nurses indicated that they would not notify the physician. The reasons for nurses failing to comply with mandated policies deserve further exploration. A future study could use a qualitative approach framing questions around the acquisition of knowledge and Benner's (1982) *novice to expert* conceptual framework.

Fourth, future studies could explore what actions the registered nurses take when medications are late. For example, do they re-time the medication or instead do they keep administration times the same? Another study might examine the perceptions that registered nurses have regarding what constitutes a non-punitive error reporting environment and what effect the documentation of names on error report forms has on their careers.

Fifth, a replication of this study using a wider population with more covariates is indicated. The aim would be to further identify predictors of nurses' actions when faced with clinical vignettes where medication administration errors occur.

Since registered nurses are faced with value conflicts daily, further research could explore the effect of these tensions on retention and job satisfaction. In addition, the paperwork entailed in error reporting might create a

fear of liability that causes some nurses to leave nursing, thus exacerbating the nursing shortage.

Development of professional values offers another area for future research. It is not known if professional values continue to develop or strengthen post graduation. Additionally, the role of the ANA *Code of Ethics* in the decision process of registered nurses on a daily basis is not known.

The relationship between ethical ideology and professional values may cause schools of nursing to consider administering the Ethical Position Questionnaire as part of a battery of pre-admission tests. Current evidence does not support administration of this instrument as an effective pre-admission screening tool. A longitudinal study may be developed to explore this area. An additional arm to that study would be to use experience-based questions during an admission interview to determine the effectiveness of that technique in admitting individuals who score high on a measure of professional values.

Limitations

The study sample was a convenience sample drawn from a four-hospital system on the south west coast of Florida. Therefore, it may not be generalizable to a region, state or nation. The investigator is employed in a non-managerial role in this system.

The sample size of 215 was smaller than the 256 that the power analysis indicated was needed. Data collection was discontinued before reaching 256 respondents because all avenues for distribution of the survey had been explored and no additional surveys had been returned in more than one week.

The post hoc power analysis indicated this study was under powered to detect significant effects of relativism on professional values (Hypothesis 1). In contrast, there was more power to detect the effects of idealism than relativism. This finding may account for the significant main effect of idealism.

The accountability instrument was author developed and had an acceptable Cronbach's alpha coefficient (.74) according to Polit (1991). Correlations between the corresponding individual questions in the two vignettes were high for the first two questions regarding documentation of time of medication administration and notification of the physician. The third question pertaining to completion of an incident report had a low but acceptable correlation. This would need to be re-tested in different situations to further develop the accountability measure.

Conclusion

Ethical idealism but not relativism was found to have a significant effect on a measure of nurses' professional values. Although absolutists (adherents to strict moral principles) scored highest on all measures of accountability, there was only one instance where ethical ideology did have a significant effect on accountability. This effect emerged when Question 3 (completion of an incident report) was analyzed separately from the other questions, while controlling for age. The study was drawn from a four-hospital health care system on the west coast of Florida therefore the results are not generalizable. Replication of the study drawing from a larger population is recommended.

Summary

This study is the first to attempt to link ethical ideology and professional values with a nurse's intention to act accountably. Ethical ideology was linked to a measure of professional values; however, it was not linked to a measure of accountability. Although not generalizable, the results of this study suggest the need for further research to ascertain the role of professional values on a registered nurse's intention to act accountably. This further exploration is important to move the body of knowledge forward in the area of accountability in nursing.

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Appendix A: Information About Subjects

SURVEY BOOKLET

FACE SHEET

Registered Nurses,

Thank you for your interest in this study. Your participation is strictly voluntary.

There is no individual benefit or risk to you for participating. All information is confidential. Your responses are anonymous. No individual data will be reported to your employer. Your consent to participate in this study is assumed if you return the completed survey booklet to the investigator.

It will take you approximately 15 minutes to complete the survey.

Before putting your completed survey in the interoffice envelope provided, look to make certain you answered all questions. Put the survey in the self addressed interoffice envelope and return to: **Sue Hartranft MS 430 by June 15, 2007.**

Thank you.

Sue Hartranft

734-6140

Information Questionnaire

Instructions: Provide answers to the following questions by circling or checking the most appropriate response.

Age: _____

Gender: Male Female

Race/Ethnicity: Caucasian African American Asian Pacific/Islander Hispanic

Native American Caucasian

What is your highest level of education? Circle one below

Diploma Associate Degree Bachelors Degree Masters Degree PhD

What is your current position? Circle one below

CNR CNI CNII CNIII Agency/Traveler Other

How long have you held this position? _____

How many years have you been a Registered Nurse? _____

What shift do you work? _____

What certifications do you hold? _____

Did you study the ANA Code of Ethics in you nursing program? Yes No

Did you take an ethics class in your nursing program? Yes No

How religious do you consider yourself to be?

Not Religious Somewhat Religious Very Religious Extremely Religious

1 2 3 4 5 6 7 8 9 10

Appendix B : Ethical Position Questionnaire

Appendix B

Ethical Position Questionnaire

Instructions: Please read each statement carefully. Then indicate the extent to which you agree or disagree by placing in front of the statement the number corresponding to your feelings, where:

- | | | |
|-------------------------|--------------------------------|----------------------|
| 1 = Completely disagree | 4 = Slightly disagree | 7 = Moderately agree |
| 2 = Largely disagree | 5 = Neither agree nor disagree | 8 = Largely agree |
| 3 = Moderately disagree | 6 = Slightly agree | 9 = Completely agree |

- ___ 1. A person should make certain that their actions never intentionally harm another even to a small degree.
- ___ 2. Risks to another should never be tolerated, irrespective of how small the risks might be.
- ___ 3. The existence of potential harm to others is always wrong, irrespective of the benefits to be gained.
- ___ 4. One should never psychologically or physically harm another person.
- ___ 5. One should not perform an action, which might in any way threaten the dignity and welfare of another individual.
- ___ 6. If an action could harm an innocent other, then it should not be done.
- ___ 7. Deciding whether or not to perform an act by balancing the positive consequences of the act against the negative consequences of the act is immoral.
- ___ 8. The dignity and welfare of people should be the most important concern in any society.
- ___ 9. It is never necessary to sacrifice the welfare of others.
- ___ 10 Moral actions are those, which closely match ideals of the most "perfect" action.
- ___ 11 There are no ethical principles that are so important that they should be a part of any code of ethics.
- ___ 12 What is ethical varies from one situation and society to another.
- ___ 13 Moral standards should be seen as being individualistic; what one person considers to be moral may be judged to be immoral by another person.
- ___ 14 Different types of moralities cannot be compared as to "rightness."
- ___ 15 Questions of what is ethical for everyone can never be resolved since what is moral or immoral is up to the individual.
- ___ 16 Moral standards are simply *personal* rules which indicate how a person should behave, and are not to be applied in making judgments of others.
- ___ 17 Ethical considerations in interpersonal relations are so complete that individuals should be allowed to formulate their own individual codes.
- ___ 18 Rigidly codifying an ethical position that prevents certain types of actions could stand in the way of better human relations and adjustment.
- ___ 19 No rule concerning lying can be formulated; whether a lie is permissible or not permissible totally depends upon the situation.
- ___ 20 Whether a lie is judged to be moral or immoral depends upon the circumstances surrounding the action.

Appendix C : Nurses Professional Values Scale Revised

Nurses Professional Values Scale-R ©

Indicate the importance of the following value statements relative to nursing practice. Please circle the degree of importance.

(A = not important to E = most important) for each statement.

Not Important	Somewhat Important	Important	Very Important	Most Important
A	B	C	D	E

- | | | | | | |
|--|---|---|---|---|---|
| 1. Engage in on-going self-evaluation. | A | B | C | D | E |
| 2. Request consultation/collaboration when unable to meet patient needs. | A | B | C | D | E |
| 3. Protect health and safety of the public. | A | B | C | D | E |
| 4. Participate in public policy decisions affecting distribution of resources. | A | B | C | D | E |
| 5. Participate in peer review. | A | B | C | D | E |
| 6. Establish standards as a guide for practice. | A | B | C | D | E |
| 7. Promote and maintain standards where planned learning activities for students take place. | A | B | C | D | E |
| 8. Initiate actions to improve environments of practice. | A | B | C | D | E |
| 9. Seek additional education to update knowledge and skills. | A | B | C | D | E |
| 10. Advance the profession through active involvement in health related activities. | A | B | C | D | E |
| 11. Recognize role of professional nursing associations in shaping health care policy. | A | B | C | D | E |
| 12. Promote equitable access to nursing and health care. | A | B | C | D | E |
| 13. Assume responsibility for meeting health needs of the culturally diverse population. | A | B | C | D | E |
| 14. Accept responsibility and accountability for own practice. | A | B | C | D | E |
| 15. Maintain competency in area of practice. | A | B | C | D | E |
| 16. Protect moral and legal rights of patients. | A | B | C | D | E |
| 17. Refuse to participate in care if in ethical opposition to own professional values. | A | B | C | D | E |

OVER

Not Important	Somewhat Important	Important	Very Important	Most Important
A	B	C	D	E

- | | | | | | |
|---|---|---|---|---|---|
| 18. Act as a patient advocate. | A | B | C | D | E |
| 19. Participate in nursing research and/or implement research findings appropriate to practice. | A | B | C | D | E |
| 20. Provide care without prejudice to patients of varying lifestyles. | A | B | C | D | E |
| 21. Safeguard patient's right to privacy. | A | B | C | D | E |
| 22. Confront practitioners with questionable or inappropriate practice. | A | B | C | D | E |
| 23. Protect rights of participants in research. | A | B | C | D | E |
| 24. Practice guided by principles of fidelity and respect for person. | A | B | C | D | E |
| 25. Maintain confidentiality of patient. | A | B | C | D | E |
| 26. Participate in activities of professional nursing associations. | A | B | C | D | E |

Please feel free to make comments:

Appendix D: Accountability Instrument

Accountability Instrument

Vignette A

Instructions: Carefully read each of the statements below. Indicate the extent to which you would respond in the situation by placing in front of the statement the number corresponding to your likely action when

Not Likely		Slightly Likely to do		Might do		Very Likely to do		Extremely Likely to do	
1	2	3	4	5	6	7	8	9	10

Situation

You are caring for a 54 year old patient who is scheduled for an IV antibiotic every 4 hours. You will need to administer at 1000 and 1400. You forget and do not administer the 1000 dose until 1200.

_____ How likely would you be to document the administration time as 1200?

_____ How likely would you be to complete an incident report?

_____ How likely would you be to call the physician?

How realistic is this hypothetical clinical situation?

Very Unrealistic		Realistic		Very Realistic				Extremely Realistic	
1	2	3	4	5	6	7	8	9	10

Accountability Instrument

Vignette B

Instructions: Carefully read each of the statements below. Indicate the extent to which you would respond in the situation by placing in front of the statement the number corresponding to your likely action.

Not Likely		Slightly		Might do		Very Likely		Extremely	
		Likely to do				to do		Likely to do	
1	2	3	4	5	6	7	8	9	10

Situation

You are caring for a 54 year old patient who is scheduled for an IV antibiotic administration every four hours. You will need to administer the antibiotic at 1000 and 1400. You forget and do not administer the 1000 dose until 1200. At that time you realize the patient has an elevated temp of 101.8.

_____ How likely would you be to document the administration time as 1200?

_____ How likely would you be to complete an incident report?

_____ How likely would you be to call the physician?

How realistic is this hypothetical clinical situation?

Very Unrealistic		Realistic				Very Realistic		Extremely Realistic	
1	2	3	4	5	6	7	8	9	10

About the Author

Susan Hartranft received a Bachelor's Degree in Nursing from Albright College in 1977 and a M.S. in Nursing from the University of South Florida in 1984. Currently employed by Morton Plant Mease Health Care in Clearwater, Florida she has responsibility for the Nursing Research Center. Additionally Ms. Hartranft serves on the Clinical Advisory Board for the University Of South Florida College Of Nursing and was instrumental in assisting the College to develop the Clinical Nurse Leader Program. She remains as courtesy faculty for the College of Nursing.

While in the Ph.D. program Ms Hartranft served as the student representative on the Ph.D. Curriculum Committee. An active member of the Florida Nurses Association she currently serves on the Board of Directors and is Chair of the Workforce Advocacy Commission. Additionally she is an inaugural member of the American Association of Colleges of Nursing Commission on Nurse Certification Board of Directors.