Development and Initial Psychometric Evaluation of Nurses' Ethical Decision Making around End of Life Care Scale (NEDM-EOLCS) in Korea

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DEVELOPMENT AND INITIAL PSYCHOMETRIC EVALUATION OF NURSES' ETHICAL DECISION MAKING AROUND END OF LIFE CARE SCALE (NEDM-EOLCS) IN KOREA

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ABSTRACT

Development and Initial Psychometric Evaluation of
Nurses' Ethical Decision Making around End-of-Life Care Scale
(NEDM-EOLCS) in Korea

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As supported by extensive literature, nurses have a role to play in helping patients and families in getting their needs understood and met. This ethical responsibility includes decisions made by nurses in the context of end-of-life (EOL) care.

Ethical decision-making is known to be influenced by nurses' understanding of their professional accountability and several cognitive processes that underlie moral action. Rest (1986) theorized these processes as: moral sensitivity, judgment, moral motivation, and moral character. However, few instruments have been developed to understand nurses' ethical decision-making during EOL care, and most have focused on a single dimension rather than on the multi-dimensional process.

The purposes of this methodological study were: 1) to develop a scale with content domains and items capable of describing Korean nurses' ethical decision-making at EOL and 2) to evaluate the scale's psychometric properties using Korean nurses (N = 230). The criteria for participation were: Korean nurses having more than 2 years of clinical experience in the types of

units where most Korean patients spend the end of their lives: critical care, general medical-surgical, and hospice units.

The process followed two steps. Phase I consisted of the development of domains and items. Three domains were identified through themes derived from an integrated review of relevant literature and the findings from a preliminary qualitative study involving experts in EOL care in Korea. 95 items were generated within these three domains. Content validation was completed by a panel of six nursing ethics experts, three in Korea and three in the U.S. Next, a pilot study to test readability was conducted using three Korean nurses. During Phase II, 67 items of the NEDM-EOLCS version 3.0 were tested. After item analysis and factor analysis, a 55-item final version of the NEDM-EOLCS was established. The total scale and three subscales reported good reliability and validity. The three subscales were labeled: "perceived professional accountability," "moral reasoning and moral agency," and "moral practice at the EOL."

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"My presence will go with you, and I will give you rest." (Exodus 33:14)

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I have a dream. When I am faced with my own end-of-life situation, I would like to hear testimony from the nurse who will take care of me: “With your teaching and learning about nurses’ ethical decision-making, I have served my patients well. Do not worry about your end-

of-life care. I'll care for you." In order for this dream to come true, I'll go where the Lord will guide me, and all of my lovely teachers, colleagues, and family members will be with me.

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CHAPTER ONE

INTRODUCTION

Statement of the Problem

According to statistics and literature, many Koreans die in a hospital setting with end-of-life decisions made by physicians and/or family members. In 2006, 243,934 people died in Korea; over 50% of the deceased (133,482) faced the end of their lives in medical institutions, and 3,072 died in residential institutions (Korean National Statistical Office, 2007). However, Keam et al. (2008) reported that most of the people who died in a hospital setting experienced less concern from healthcare providers related to the provision of hospice and palliative care than those who died in a residential institution. The final wishes of patients who die in a hospital setting often are ignored without advance care planning from healthcare providers. Moreover, end-of-life (EOL) decisions in the hospital setting frequently are made by physicians working in these institutions, not by the patients (Han et al., 2003). Most EOL decisions in Korea, in fact, are made by family members and physicians without patient involvement (Han et al., 2001; Kang & Yum, 2003; Han et al., 2003; Kim, 2005; Shim et al., 2004; Han, 2005; Kim, 2008a).

During these EOL situations, Korean nurses tended to support patients' preferences in the decision-making process (Han, 2005), while doctors believed that a decision made by the family with the support of a physician is the appropriate way to decide on do-not-resuscitate (DNR) issues (Lee, 2007). Despite Korean nurses' intentions to support patient preferences and their attitudes toward EOL care, the reality in the practice setting is that nurses are less involved in

EOL decision-making than their intentions suggest are necessary (Kim, 2005). Because of this discrepancy between Korean nurses' attitudes toward and involvement in EOL decisions, Korean nurses reported suffering (Jo, 2004), feelings of burnout (Leou, Kim, & Kim, 2005), and emotional burdens and ethical conflict related to taking care of patients and family (Kim, 2004). They are experiencing moral distress both during the decision-making process and after the decision is made (Kim, 2004). In summary, Korean patients—for the most part—do not get what they need at the end of their lives, and Korean nurses see themselves as unable to speak up for the patients' needs. This is a huge ethical issue in nursing practice because it interferes with the ability of nurses to promote the patients' welfare. This issue needs further exploration to discover what the barriers are to meeting patient needs before it can be addressed properly.

Currently, the conditions in Korea related to EOL care are ripe for nurses to increase their moral agency on behalf of patients who are approaching the end of their lives. Recently, there has been a movement to raise concern about EOL care at the national health policy and global health policy levels. The Korean situation can be informed by changes in the United States related to how end-of-life care is understood.

In the United States, the "Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment" (SUPPORT) was conducted and completed in 1995. This was a large study undertaken in two phases. It was aimed at both understanding the preferences of patients in the terminal stage of their illnesses and how well these preferences were communicated and respected (SUPPORT Investigators, 1995). This study showed that problems with ethical EOL care, at least in institutional settings, are multidisciplinary in nature. This study and other literature have contributed to a movement to address the problems associated with end-of-life care, especially as it occurs in institutions. The Institute of Medicine (IOM) (2001) has focused

some of its efforts on "Improving Palliative Care for Cancer." Additionally, the National Institute for Nursing Research (NINR), a branch of the National Institutes of Health (NIH), has viewed as a priority funding initiatives aimed at improving EOL nursing care (Heitkemper, 2005). This movement also has had an effect on Korean EOL policy and education.

In Korea, the Ministry of Health, Welfare, and Family has supported hospice and palliative agencies financially since 2005. The Korean National Cancer Center leads the development of hospice and palliative care curriculum for health care providers. Additionally, issues associated with EOL care are starting to be taken seriously in Korea. Since the landmark Boramae Hospital case[1] brought attention to end-of-life issues in Korea, there has been a proposal to build a social and professional consensus and guidelines for EOL decision-making and legal standards (Han et al., 2005, Korean Medical Association, 2006; Korean Nurses Association, 2006). Ten years after the Boramae Hospital case, the plight of another patient, Ms. Kim, again has raised the attention of the public regarding EOL issues. In 2009, the Korean Supreme Court made a decision enabling healthcare providers to remove the mechanical ventilator that was maintaining Ms. Kim's breathing. She was a 79-year-old woman in a coma (McGuire, 2009; Fox News, 2009). This increased national and global attention to end-of-life care makes it possible for patients to experience more positive outcomes that are aligned with their wishes. Nurses, because of their more sustained and often more basic relationships with patients and their families, have important roles to play.

In many EOL situations, the problem is when and how to redirect the focus of care and intervention from aggressive, life-sustaining treatment to palliative care. Sometimes decision-

[1] In 1997, the wife of a patient who underwent brain surgery at Boramae Hospital asked doctors to stop further treatment of her husband due to the financial burden upon her family. A doctor allowed the patient to be discharged against medical advice, and he subsequently died. In 1998, the court proclaimed that stopping treatment was illegal and found both doctor and the wife guilty of homicide.

making for a given patient is straightforward, but more often than not, it is difficult and complex, and the patient's needs, preferences, and wishes may go undetected or ignored. Nurses, because they are in the closest proximity to patients and their families, are often in a position to assist patients and their families in being clear about the goals of treatment, clarifying the situation, and eliciting from them what their preferences and wishes are. If nurses do not take this responsibility seriously, then patients and/or their families are unlikely to get optimal care that is tailored to their particular interests.

Nurses play a major role in helping patients and families make decisions with respect to EOL issues by virtue of 24-hour caring relationships. Nursing literature has documented the many obstacles to nurses' understanding and communicating a patient's wishes. Thus, it can be seen that the quality of end-of-life care for a patient often depends upon how nurses perceive their roles in end-of-life care situations and how likely they are to engage in appropriate action on behalf of the patient. Therefore, ethical decision-making by nurses about what is needed for good EOL care for a given patient is not only the consequence of moral reasoning based on an understanding of the responsibilities incurred in being a nurse but also on the integrated process of perceiving the ethical nature of the issue, judgment about what actions will facilitate the patient's welfare, motivation to carry out the actions even in the face of conflict, and perseverance in implementing necessary actions (Rest, 1986; Cassidy, 1996).

While some studies have focused on understanding nurses' actions during EOL situations, this body of knowledge remains immature. More studies are needed to strengthen conceptual aspects, provide rigor, and understand culturally-related differences in role expectations and perceptions. First, there is no research tool that measures nurses' ethical decision-making in end-of-life care situations from the perception of a problem through action

taken. Most tools measure only one or at most two aspects of the process of perceiving a problem through ensuring the completion of appropriate action. The concepts of knowledge, attitudes, perception, and experiences are used widely as variables in EOL care research for health care providers (Levetown, Hayslip, & Peel, 2000; Thibault-Prevost, Jensen, & Hodgins, 2000; Cramer et al., 2003; Jezewski et al., 2005; Schereret et al., 2006), but those concepts have been explored using one or more linear causal relationships rather than an integrated process. Moreover, most instruments did not cover ethical issues at all. Neither did they understand how nurses resolve problems or what actions they take but, rather, how they perceive and experience ethical issues in their practice (Fry & Duffy, 2001). Second, existing tools often do not give information about psychometric evaluation. Some instruments reviewed by the author reported reliability but had a low alpha score, thus giving rise to ambiguity related to rigor and thus usefulness. Third, the existing tools do not permit accounting for differences arising from the cultures within which nurses' practice.

In Korea, some studies have measured one of the moral components inherent in decision-making in nursing, such as nurses' moral sensitivity (Han et al., 2007; Kim et al., 2005; Yoo & Park, 2005) or nurses' moral reasoning (Kim, Park, & Han, 2007; Lee et al.; 2007; Kim et al.; 2004; Kim & Park, 1998); however, no studies have measured the whole process of reasoning that culminates in a nurse's moral action on behalf of a patient who is involved in a specific end-of-life situation.

To advance knowledge about ethical EOL care, valid instruments that can account for ethical perspectives, cultural nuances, well-differentiated domains, and variables are required. Such tools will be likely to permit an understanding of what is needed to enhance nursing practice for patients who have reached the end of life. The purpose of this research endeavor was

to develop and evaluate a tool to measure Korean nurses' ethical decision-making in end-of-life care situations.

Purpose of the Study

The purpose of this study was to develop a tool to measure Korean nurses' ethical decision-making in end-of-life care situations. A tool was developed that isolated appropriate content domains and items as validated by psychometric testing. The specific objectives of this study were to gain clarity about the following questions:

1. What are appropriate domains and items for measuring ethical decision-making in end-of-life care situations among Korean nurses?
2. Is the newly developed instrument valid and reliable to measure ethical decision-making regarding end-of-life care among Korean nurses?

Conceptual Framework

As a conceptual framework to understand Korean nurses' ethical decision-making regarding end-of-life care, nurses' professional accountability and Rest's (1986) components of moral reasoning and action were used within the context of "good" care at the end of life. Figure 1 shows the details of this framework.

Nurses' Professional Accountability for Good Patient Care

The nursing discipline has determined over time what its goals and purposes are. While there are differences in understanding with respect to the status of the professional nursing role among countries, there are also many similarities. Nurses' professional responsibilities are addressed by both international and national codes of ethics for nurses (Milton, 2004; Mylott,

2005). The International Council of Nurses' (ICN, 2006) code of ethics, for example, has declared nurses' responsibilities as being: "to promote health, to prevent illness, to restore health and to alleviate suffering" (p. 1). The Korean Nurses' Association (2006), meanwhile, has declared Korean nurses' responsibilities as being: to be an advocate, to judge ethically, and to act morally in the nurse-patient relationship. Thus, the nurse has a responsibility to attend to the patients' good. However, his or her understanding of what this entails and willingness to follow through with ethical decision-making and action is understood best within the framework of Rest's (1986, 1999) work on the processes underlying moral agency. Rest (1986, 1999) derived his framework from "the contemporary theory and literature of disparate disciplines," and "(his) insights cohere" with those "synthesized from nursing and allied literature" (Grace, 2009, p. 59).

Nurses' Moral Components at EOL

In order to develop an understanding of nurses' ethical decision-making regarding end-of-life care, Rest's four-component model (1986, 1999)—used as a basic conceptual framework within end-of-life care contexts—is appropriate. Rest's original thought (1983, 1986, & 1999) was that moral behavior is achieved as a result of a complex, inner, psychological process that has various interrelated components such as moral sensitivity, judgment, motivation, and character with respect to action. These components interact, influence each other, and are integrated. They result in moral agency, even under difficult circumstances. In other words, nurses' moral action follows a process of: "interpretation of the situation, [and] discerning the moral ideal action (Asking). What ought to be done? Deciding what to do, and implementation and perseverance" (Grace, 2009, p. 60-61). During difficult or problematic end-of-life situations, ideally, this process, guided by an understanding of disciplinary goals and responsibilities, leads

to good care for patients and their families. Rest's (1986, 1999) model helps us gain insight into how nurses engage in moral behavior in specific situations.

Nurses' Moral Behavior

Nurses' moral behavior is an action for reaching the goal of nursing; i.e., providing good care (Gastmans, de Casterlo, & Schotsmans, 1998; Lindh, Severinsson, & Berg, 2007; Grace, 2009). It is influenced directly by nurses' professional accountability as well as through the integration of nurses' individual moral components. Rest's moral components model assumed that "moral action is the product of each of component's processes operating in combination and interaction" (Thoma, Rest, & Davison, 1991, p. 660).

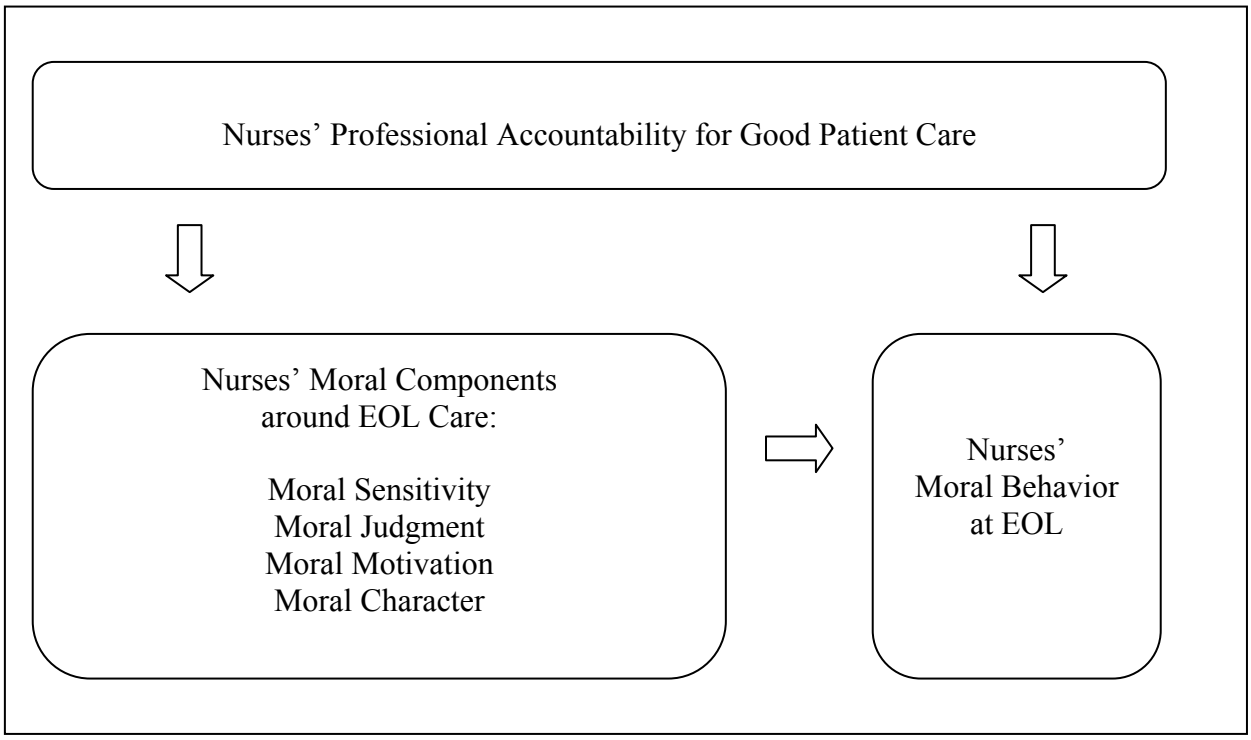

Figure 1. Conceptual framework of nurses' ethical decision-making with respect to EOL care.

Definition of Term

Ethical Decision-Making

Nurses' ethical decision-making is a critical dimension in nursing practice. It is a complex "process requiring nurses to identify and to evaluate alternative actions—as well as their consequences—in order to determine what they ought to do" (Erlen & Sereika, 1997, p. 954). In this research, ethical decision-making can be defined as a sequential process and outcome of ethical integration through professional accountability and moral components with moral sensitivity, judgment, motivation, and implementation—through moral behavior—of what is good for the patient.

End-of-Life Care

End-of-life care can be defined as a broad approach to care during a chronologically indefinite period of time during which patients and their caregivers are struggling with the implications (e.g., symptoms, practical support needs) of a chronic illness (Lorenz et al., 2005) such that the patient is experiencing exacerbated physical decline with little possibility of recovery.

Significance of the Study

This study may contribute to nursing knowledge development by linking ethical nursing actions and end-of-life care in Korea. By exploring how nurses in Korea both reason and act during end-of-life care situations, this study ultimately may highlight perceived or actual barriers to carrying out what nurses understand to be "good" actions and permit the design of

interventions, as they are validated by the study, that will address barriers to ethical action during end-of-life care.

Summary

This chapter has addressed the statement of the problem, purpose of the study, conceptual framework, definition of terms, and significance of the study for developing and testing nurses' ethical decision-making with respect to end-of-life care scale.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This chapter explores and critiques the current body of literature that focuses on nurses' ethical decision-making on behalf of, or in conjunction with, patients who are at the end of their lives. First, the process of ethical decision-making within a caring relationship is explored. The caring relationship has been viewed by many as essential for 'good patient care'. This idea is discussed in the context of a nurse's responsibility. Next, pluralistic philosophical underpinnings are addressed to explain the ethical nature of nurses' decision-making in practice situations. Then, the concept that nurses have ethical responsibilities in general care situations and in end-of-life situations is explored. After addressing nurses' professional accountability, the idea that there are several cognitive components of ethical/moral decision making that results in action - based on Rest's four-component model - is discussed. Finally, the state of the science related to measuring nurses' ethical decision-making especially regarding end-of-life care is discussed in terms of existing nursing knowledge but particularly as applied to the context of nursing in Korea.

Nurses' Responsibility and Nurses' Ethical Decision-Making

Providing good care to patients and their families is the nurse's professional responsibility (Gastmans et al, 1998; Lindh et al, 2007; Grace, 2009). Good care is equivalent to "ethical practice" (Grace, 2009, p. 5), and is based on nurses' ethical decision-making through the integration of clinical and moral reasoning. In addition, given the caring relationship between

nurses and patients, nurses make judgments about what is good for patients every day and everywhere in their practice. These judgments require the nurse to have in mind interventions and alternatives that pose the greatest benefit to their patients (clinical reasoning). This involves a process of reasoning that is based on a deep understanding of human beings and analysis of empirical knowledge that will allow the nurse to determine the best way to solve a patient's problems (moral reasoning). Therefore, a nurse's professional responsibility to provide good care is directly related to a nurse's ethical decision-making.

In the nursing literature, nurses' ethical decision-making was illustrated in terms of both process and consequences. First, antecedents are events or behaviors that occur before ethical decision-making takes place. Personal and/or institutional values and professional obligations are considered as antecedents. Noureddine (2000) reported that values and ethical principles were the basis of ethical decision-making in nursing. Ketefian (1985) defined ethical decision-making as the respondents' assessment of the extent to which nursing actions in simulated ethical dilemmas that are in accord with the tenets of the nursing profession's ethical code are likely to be implemented in practice. Analyzing antecedents proves meaningful when attempting to find a target point for enhancing ethical decision-making.

Integration as a process is viewed as a second perspective in ethical decision-making. Grundstein-Amado (1993) defined ethical decision-making as a process of choice leading to action influenced by both context and content. Context refers to the relationship between professionals and patients, and to the institutional context in which the decision has taken place. Consequence, the third perspective by which to view ethical decision-making, reveals results or outcomes. The theory of a peaceful end of life, constructed by Ruland and Moore (1998), provides an example of consequences of ethical decision making in end of life care. Their

outcome criteria that constitute the elements of a peaceful end of life are: not being in pain, the experience of comfort, the experience of dignity and respect, being at peace, and closeness to significant others or other caring persons. According to the review of literature, variables such as satisfaction, decisional conflict, anxiety or stress, and involvement in the decision-making process were tested as consequences of ethical decision-making (Weinfurt, 2003). However, as Weinfurt (2003) pointed out it is also necessary to understand the decision making process of patients.

In end-of-life situations, nurses' ethical decision-making is understood as a sequential process that attempts to achieve the best possible end for the patient and inevitably requires some understanding of what the person's values, beliefs and preferences are. Furthermore, this decision-making process through a caring relationship is understood to be a nurse's responsibility. Caring requires knowing something about the patient which in turn requires a knowledgeable, skilful nurse who understands the importance of the nurse patient relationship and can engage with the patient – or family members when the patient can't communicate – to elicit the patient's preferences (Grace, 2009). Nurses' ethical decision-making is dependant to some extent upon the quality of the nurse-patient relationship. Partnership between nurses and the patient helps nurses clarify how they should, or are to, support the patient. Being a partner with the patient is another responsibility (Gallant, Beaulieu, and Carnevale, 2002). According to Gallant et al.'s (2002) concept analysis of partnership between nurse and patient, partnership consists of relationship, role and responsibilities of the partners. Partnership is a process with power sharing and negotiation to empower client at the end. Partnership involves a decision process such as relationship, shared power, and shared decision-making (Hook, 2006). Nurses'

ethical decision making in caring relationship with nurse and patient can be understood as a process and outcome for helping the patient feel empowered to say what they want.

Philosophical Underpinnings Regarding Nurses' Ethical Decision-Making

Nurses' ethical decision-making is a complex phenomenon that is hard to explain from one particular perspective. Looking at pluralistic philosophical underpinnings for nurses' ethical decision-making may help this research integrate a conceptual framework that is useful both for this and future studies. Unique nursing perspectives from caring ethics and three philosophical perspectives from deontology, teleology, and virtue ethics may help describe how nurses 'should' behave in order to achieve the good of patients. These three common philosophical perspectives derive from moral theories developed over time about what is 'good' for human being to pursue or how they should act. They are commonly seen to conflict with each other. For example, strictly following deontology or duty may lead to bad consequences (conflict with the prescriptions of teleology – that action should be directed towards achieving good consequences) (Grace, 2009, pp. 12-19). Insights from the literature review reveal that the theories are not as conflictual as supposed if they are applied to different parts of the decision-making process and are integrated using the idea of achieving nursing goals as the ultimate aim.

Caring ethics could provide basic guidance in nurses' ethical decision-making. Caring ethics originated from feminist ethics. The ethics of care emphasize traits valued in intimate personal relationships (Fry & Johnston, 2002; Grace, 2009). Caring implies a commitment on the nurses' part to protect human dignity and preserve humanity. Caring, an inter-subjective human process, is the moral ideal of nursing (Chinn & Kramer, 2008). Some have critiqued the ideal of 'caring' as being problematic for nursing (Nelson, 1992). Nelson questions how we can

determine what the right actions are just by intentionally engaging with the patient to find out his or her particular needs. The answer may be that "we can't", we need the perspective of nursing knowledge and nursing goals to integrate with knowledge of patient desires, preferences and contextual needs.

Deontology is focused on moral duty and obligation, which are central notions for moral action (Johnstone, 2009). Moral duty is expressed by professional and moral obligation. The obligation to respect each person emphasizes essential moral duties or principles. These principles, which are important to nursing practice, include doing good (beneficence), avoiding harm (non-maleficence), respecting freedom of choice (autonomy), speaking truth (veracity), loyalty (fidelity), and respecting equality (justice) (Fry & Johnstone, 2002). The obligation has been argued to exist because of the vulnerability of patients to their health needs and the responsibility of professionals to provide the service they say they can offer (Grace, 2009). The responsibilities of professionals are outlined in their codes of ethics as discussed later.

Teleology involves judging actions as right or good on the basis of their consequences (Jonestone, 2009). Teleology is focused on the last part of consequences or outcome of decision-making. Considering the goals of nursing, the final goals or the consequences of nursing fit with the patient's good. That is they are aimed at helping to meet a patient's real needs. These real needs are discovered both by understanding something about the patient – an intentional focus on discovering these (caring) and by applying knowledge, experience and skills to the task of getting these needs met.

Virtue ethics emphasizes well-intentioned, moral characteristics as an important determiner of ethical decision-making. The philosophical tradition of virtue ethics started with the ancient philosopher, Aristotle. Aristotle described virtues as habitual patterns of perceiving,

feeling, and behaving (Volrecht, 2002). Since Aristotle, several other philosophers have discussed virtue ethics and its relevance for modern life most recently Elizabeth Anscombe (1958/1981), Bernard Williams (1985) and Alasdair MacIntyre (2007) among others. Virtue ethics has been critiqued in nursing for a variety of reasons including that it can't guide action and is a rather vague concept (Begley, 2005). Additionally, it has been argued that it may lead to docility in the face of conflict which poses problems in terms of changing problematic practice or political contexts. To be virtuous in situations where there is conflict may put the nurse at risk, knowledge from behavioral psychology reveals that human beings are not capable of being consistently virtuous (Miller, 2003). However, if virtue is seen as the characteristics necessary to ensure 'good' practice and these are seen in terms of what is likely to meet professional goals some of the criticisms can be overcome.

Factors Influencing Ethical Decision-Making and End-of-Life Care

To provide good within the context of a caring relationship with the patient, how the nurse understands his or her professional accountability and other components of the cognitive process of moral agency may be factors in ethical decision- making. These next sections discuss the factors influencing ethical decision-making and end-of-life care.

Professional Accountability

In terms of professional accountability, the nurses' code of ethics provides a sense of what nurses ought to do (Milton, 2004). The professional nurses' ethical declaration, or code of ethics, represents their responsibilities in their nursing practice. The International Council of Nursing (ICN) code of ethics provides fundamental values and core elements for nurses (ICN, 2006). Its' development was informed by nurses in the constituent countries (129 countries

represented as of 2009). In addition, this code also provides an ethical declaration with respect to nurses who are practicing in numerous cultural and ethical environments; that is to say, the code is flexible, culturally sensitive, and situation-specific, and provides a detailed framework for a moral foundation in practice.

The ICN Code of Ethics for Nurses has proclaimed that nurses have four fundamental responsibilities: to promote health, prevent illness, restore health and alleviate suffering. The four principal elements of the ICN Code of Ethics for Nurses are nurses and people, nurses and practice, nurses and profession, and nurses and co-workers. has suggested a guide for action based on social value and needs by the nursing literatures.

In the United States, the Code of Ethics for Nurses with Interpretive Statements (American Nurses Association, 2001) supplies nine provisions, which contain the most fundamental values and commitments in regard to the nurse's duties, loyalty and duties beyond individual patient encounters. It provides guidelines for American nurses to use in ethical analysis and decision-making. Mylott (2005) discussed the nurse's ethical role during end-of-life care that she adapted from the ANA code of ethics. She notes that the provisions of the code imply that the nurse must act to minimize unwarranted or unwanted medical treatment and may administer interventions to relieve symptoms.

The Korean Nurses Association (KNA) declared its own code of ethics in 1972. After modification in 1983, 1995, and 2006, the current ethical declaration (KNA, 2006), ethical principle (KNA, 2006), and ethical guideline (KNA, 2007) was established for explaining Korean nurses' accountabilities. According to the most recent revisions to the Korean nurses' ethical declaration (2006), Korean nurses have the responsibility to be an advocate; maintain ethical judgments regarding the application of technology, including life science for medical

treatment; enhance the quality of nursing; and cooperate with all healthcare professionals, for the benefit of their patient's health. The current version of the ethical principles and guideline of KNA incorporated additions to highlight nurses' moral practice and their responsibility to apply advanced technology in their role as advocates for people who are need of protection (Han et al., 2005). The following quotation is the Korean nurses' ethical declaration:

> We, nurses, have been bestowed with the noble mission of contributing to the development of country and humanity by protecting the dignity and rights of its people.
>
> We promise to enhance the health and well-being of all through our nursing and pledge to carry out the following:
>
> We will maintain our prestige and dignity as professional nurses in all situations, and diligently carry out our roles as advocates of peoples' health with the highest standards in nursing care.
>
> We will maintain ethical judgments regarding the application of technology, including life sciences for medical treatment, which may impact upon human dignity, and never take part in unjust or unethical medical practices.
>
> We will endeavor to enhance the quality of nursing and respect the unique roles of, and cooperate with, all healthcare personnel, for the benefit of people's health.
>
> We solemnly swear that we will maintain this pledge with sincerity, and do our best to carry out our mission as professional nurses. (Korean Nurses Association, 2006).

As stated in the declaration, Korean nurses' accountabilities can be summarized as these: to be an advocate, to judge ethically, and to act morally in the nurse-patient relationship.

At the end of life, nurses have ethical responsibilities as well. A nurse's ethical action, in practice, may be defined as an act that attempts to achieve a desirable moral outcome where

'moral' means the patient's needs are met. Moral action is not only a thought, but a thought that leads to some action accomplished (Fry & Johnstone, 2002). In end-of-life situations, desirable moral outcomes are drawn by the nurse's code of ethics (Mylott, 2005) and rooted in the goals and purposes of the nursing profession.

Providing a peaceful end of life for a patient (Ruland & Moore, 1998) to facilitate the patient's physical and psychological comfort, their spiritual well-being, the management of their pain, and a good relationship, is one of the nurse's accountabilities. One of the responsibilities of a nurse who cares for patients at the end of life is to uphold the patient's wishes by supporting the decision-making process and providing information that enhances the patient's understanding. Nurses often stand between a patient's autonomy and the physician's paternalism, and have a responsibility to be an advocate for patients (Breier-Mackie, 2001; Thacker, 2008).

Moral Components

While the foundations of nursing's professionals responsibilities are in professional goals and purposes, and are outlined in codes of ethics - thus nurses must first understand that by reason of being a nurse they are responsible for good practice - many things get in the way of good decision-making. To better illustrate those factors that influence a nurse's ethical decision-making, Rest's four-components model of the cognitive processes involved in moral decision making and agency (1983) is useful (Fry & & Johnston, 2008; Grace, 2009). In contrast, the Defining Issues Test (DIT) developed by Rest only focused on measuring the second component, moral judgment. Moral behavior cannot be explained by one single component of moral judgment. The interaction, integration, and influence of the four components of moral sensitivity,

moral judgment, moral motivation, and moral character for implementation may describe moral behavior (Rest, 1983, 1986, & 1999).

Moral sensitivity can entail "interpreting the situation, role taking how various actions would affect the parties concerned, imaging cause-effect chain of events, and being aware that there is a moral problem when it exists" (Rest et al., 1999, p. 101). Moral sensitivity is the first step in taking moral action, and a basic component of the decision-making process in professional practice (Jordan, 2007). According to Weaver's review of the literature (2007), ethical/moral sensitivity has been defined in three ways in nursing: "the identification of number of ethical issues, recognition of the unique characteristics of situations and persons receiving care, and attitudes to issues" (p. 143). Grace (2009), whose work on professional responsibility involved a philosophical analysis of the concept of advocacy, argues that moral sensitivity in nursing practice is the understanding that all practice situations are inherently ethical in nature. For this reason nurses can be criticized to the extent that any action they take in practice and related to patient care is aimed at achieving nursing goals. Fry & Johnston (2008), nursing ethics scholars in their work on ethical decision-making, point out that nurses' insight, intuition, moral knowledge, and the recognition of silent cues are also necessary to moral sensitivity. This moral sensitivity may differ from person to person based on their culture, religion, education, and experiences.

Moral judgment is defined as a component which is "judging which action would be most justifiable in a moral sense" (Rest et al., 1999a, p. 101). In the practice of nursing, moral judgment is a logical conclusion based on evidence as well as intuition (Fry & Johnston, 2008). Grace (2009) explains that moral judgment involves "discerning the morally ideal action and what ought to be done" (p. 61). According to Grace, "by using appropriate tools, methods, and

resources for decision-making as well as identifying the beneficiary, the goal, appropriate action" (p. 61), nurses may judge morally.

Moral motivation, one of moral components, is defined as "the degree of commitment to taking the moral course of action, valuing moral values over other values, and taking personal responsibility for moral outcome" (Rest et al., 1999a, p. 101). Moral motivation is a nurse's willingness. Combined with moral responsibility, moral motivation helps people make a commitment to achieving a good moral outcome (Fry & Johnston, 2008). Grace (2009) explains moral motivation as "deciding what to do" (p. 61) in spite of ambiguity, uncertainty about outcome, and lack of institutional or peer support.

Moral character is a quality defined as "persisting in a moral task, having courage, overcoming fatigue and temptations, and implementing subroutines that serve a moral goal" (Rest et al., 1999a, p. 101). It is evidenced by perseverance to and implementation of a moral action (Fry & Johnston, 2008; Grace, 2009); those with moral character are capable of "envisioning the steps and anticipating problems, addressing and overcoming problems and barriers, taking sociopolitical actions to get what is needed, keeping sight of the goal, and reminding others of the goals" (Grace, 2009, p. 61).

During end-of-life situations, nurses should perceive their accountability and moral components in accordance with the nurse's code of ethics. Nurses can integrate moral components, and justify what they ought to do, and then take actions that result in the best approach for a patient A nurse's ethical decision-making attains the ultimate goal when patients become peaceful and find meaning and hope during end-of-life situations. A nurse's own perception, attitudes, and beliefs toward end-of-life care affect end-of-life decision-making. Several published papers show that nurse's perception, attitude, and personal beliefs influenced

to nurses' competency about end-of-life care (Thibault-Prevost et al., 2000; Oberle & Hughes, 2001; Georges et al., 2002).

Societal contexts such as cultural, economic, and legal influences affect both the nurse's and the patient's decision-making in end-of-life care situations (Cohen & Palos, 2001; Kagawa-Singer & Blackhall, 2001). Thus all of these are considerations.

Compared to westernized cultural perspectives, which respect individual decision-making ability, oriental cultures tend to be more focused on family decision-making in end-of-life care (Valente, 2001). Health policy or insurance coverage regarding end-of-life care may influence decision-making as evidenced in the Boramae case. Thus, legislation regarding end-of-life care policy may facilitate these processes. In end-of-life decision-making, ethical sensitivity regarding preferences, beliefs, and attitudes among patients, family, and healthcare providers may also affect the decision-making process as antecedents. Nurses assess patients' preferences and attitudes at the individual, extended community, and societal levels. Based on this author's review of the literature a knowledgeable and caring relationship between a nurse and a patient with appropriate communication about end-of-life care may facilitate and support the whole process in a positive manner.

During end-of-life situations, nurses make judgments that are based on what they think is best for their patients and their families. This judgment requires a process of reasoning that often includes the consideration of numerous alternatives, the nurse must try to decide what will produce the greatest good for their patient. This reasoning process is based on the analysis of empirical data and a deep understanding of the situation at hand. When the nurse understands his or her professional responsibility and engages in the process of decision-making, the hope of the nurse is to produce the best possible solution to the patient's problems.

Moral responsibility as a professional care provider is just one of many examples of moral motivation. During end-of-life care, nurses often face a number of ethical decisions and responsibilities. The obligation of the nurse is to uphold a patient's right to self-determination through supporting the decision-making process. This can be done by providing information that enhances the patient's understanding of the decision-making process. Breier-Mackie (2001) pointed out that nurses often stand between a patient's autonomy and a physician's paternalism and suggests that nurses have a responsibility to be an advocate for patients. To sum up, during the end-of-life situation, nurses have responsibilities as direct care providers, supporters, coordinators, and advocates for quality care. One of the roles that a nurse plays is as an advocate for the wishes of the patient; these wishes, with cultural considerations taken into account, often need to be conveyed to the family toward the end of life (Thacker, 2008). Thacker (2008) described nurses' perception of advocacy behavior at the EOL setting in critical care. Her subjects were 317 critical care nurses. This comparative study reported that both novice nurses and expert nurses recognized advocacy behavior as part of their role in end of life practice no matter what the is institutional supports or barriers are. Nurses ought to facilitate decision-making through providing proper information and supporting the patient and the family, while advocating the patient's autonomy. Based on decision-making information that comes directly from patients and family, a nurse must provide care to relieve pain, prevent suffering and minimize unwanted aggressive medical treatment.

A nurse's moral character determines his/her actions; these actions can be defined as things that someone does in order to achieve a desirable moral outcome through implementation. Moral implementation is not only a thought but an act (Fry & Johnstone, 2002). The concept of moral distress is often dealt with by nursing researchers in an attempt to define the moral

dilemma that nurses are prone to experience (Corley et al., 2001; Elpern et al., 2005). It is all about negatively pointing out obstacles, frustration, and the lack of resources and support that nurses often have to deal with. Currently, Breakey (2006) generated a theory of optimizing stewardship that explains how nurses engage in end-of-life decision-making as an example of moral character in a positive way. Using grounded theory methodology, she generated a theory of nurses' participation in life sustaining treatment decision making with eleven critical care nurses. According to her results, during the care of patients who are involved in a life-sustaining treatment decision, nurses have experienced empathic distress, active engagement, and maximization of moral leadership. As a result of this moral leadership, nurse and patient achieved peace of mind regarding treatment decisions, providing a peaceful end. In sum, nurses often feel moral distress at the end of life care situation however nurses who exercise moral agency both facilitate their patient's good and experience relief from their feelings of distress.

Measuring Issues Concerning the Nurse's Ethical Decision-Making at the EOL

Issues in existing nursing knowledge

While we know that a nurse's ethical decision-making regarding patients depends on their professional accountability and various moral components, previous studies insufficiently measure the entire cognitive process that leads to action. This next section provides a discussion of existing research and its limitations in terms of nursing knowledge especially related to ethical EOL care.

There are many research trials regarding end-of-life care that do not cover the ethical aspects involved in providing care during the dying process. The concepts of knowledge, attitudes, perception, and experiences are widely used as variables in end-of-life care research for

health care providers. The Physicians' End-of-Life Attitude Scale (PAES) attempts to measure the physician's attitude toward the outcome of palliative care education (Levetown et al, 2000). Similar research tried to study nurses' attitudes and/or perception of end-of-life care in various populations such as critical care nurses (Thibault-Prevost et al., 2000) and nurses who were employed at selected community hospitals (Cramer, McCorkle, Cherlin, Johnson-Hurzeler, & Bradley, 2003). The Knowledge, Attitudinal, Experiential Survey on Advance Directives (KAESAD) was administered to oncology nurses (Jezewski et al., 2005) and critical care nurses (Scherer, et al., 2006) in the U.S.. The findings of these surveys with KAESAD show that nurses are not very knowledgeable about the Patient's Self Determination Act (PSDA) that was passed in the U.S. in 1991 and was designed to raise consciousness related to honoring patient preferences for care and acceptable interventions. Nurses were also not confident about helping patients complete their advance directives.

The concepts related to the nurse's caring activities, practice, and behaviors have been measured through several studies. Downey et al. (2006) tried to measure nurses' perspectives on family-centered end-of-life care in the intensive care unit. Their instruments consisted of three parts: activities, barriers, and meeting family needs. The End of Life Care Decision Questionnaire II (EOLCDQ II) is designed to collect data on both perception and behavior regarding end-of-life care (Stoekle, Doorley, & McArdel, 1998). The Appropriate Care Questionnaire (ACQ) tried to measure the extent of nursing activities with hypothetical scenarios. However, concepts addressed in existing scales are not comprehensive enough to explain how health care providers attempt to reach the good of the patient in an end-of-life context through ethical decision-making. The concepts related to ethical issues have been measured in end-of-life care. The Ethical Issues Scale (EIS), developed by Fry & Duffy (2002),

resulted from a survey of 2090 nurses in six New England States and across a variety of practice settings. The survey reports how often nurses encounter ethical issues in practice and how disturbing they find them, but was not aimed at discovering how nurses resolve ethical issues. This instrument did report psychometric validity.

Also, the instruments reviewed for this study vary in their reliability, and internal consistency. Thus, some of the instruments could not be relied upon and would need further testing. Even though nurses who care for patients at end of life have faced ethical problems, most of the instruments do not cover these ethical issues adequately, except for patients' autonomy. These prior instruments measured causal relationships rather than the sequential process of ethical decision-making in end-of-life care.

In 2004, the NIH laid out some guidelines - based on research and in response to the well publicized problem of end-of-life care in the U.S - for the future direction of research on the issues surrounding end-of-life care. Issues surrounding EOL care are complex and thus research studies must be carefully crafted. Consequently, a panel of experts proposed that a framework and valid tools for measurement need to be developed. Moreover, measurement tools require testing for equivalence, validity, and sensitivity to change within and across different groups (NIH, 2004). As NIH states, in the context of the end of life, there exists a necessity to develop a tool within the proper theoretical framework regarding ethical aspects, with consistency among the concepts, domains, and items of tools. A proper psychometric evaluation is also a necessity. It is necessary to report not only reliability, but also criterion-related content and construct validity. Instruments also need to deal with general and particular cultural diversity.

Issues in Korean nursing

In Korean nursing, a few studies have been carried out regarding ethics and ethical decision-making related to general nursing practice. Yoo & Park (2005) conducted research that examines how clinical nurses understand and are made aware of bioethics regarding human life. 312 Korean nurses were surveyed. The findings note that Korean nurses' extent of awareness about bioethics significantly differ from their education, religion, and job satisfaction. Some trials have been conducted on ethics for nursing students (Han & Ahn, 2000; Park et al., 2003). Han & Ahn (2000) studied 100 Korean senior undergraduate nursing students and described ethical dilemmas which they had experienced in their clinical practicum. The most frequently experienced dilemmas for Korean nursing students were identified: "families giving up on a patient who cannot be cured' and 'not telling the truth to the patient" (p122). In a phenomenological study, Park et al. (2003) described that Korean nursing students experienced ethical conflicts about right thing to do and that using an ethical decision making model which they learned during nursing ethics education helped them resolve the problems or gave them the rationale for resolving problems. These studies revealed that Korean nursing students experience ethical conflict in their clinical practicum and nursing education may help them to resolve the problem. However, there remains a gap in knowledge about how Korean nurses resolve an ethical conflict and what actions they take to ensure that they provide a good for their patient.

Measuring moral components has been attempted in Korean nursing research. Most of the research has been focused on moral reasoning and moral judgment among nurses (Lee et al., 2006; Kim, Park, & Han, 2007) and nursing students (Kim et al., 2004; Lee, Kim, & Hong, 2005; Kim & Park, 2005; Lee et al., 2006; Kim, Park, & Han, 2007; Lee, 2008) with the Defining Issues Test (DIT) developed by Rest (1979). However, research outcomes that use DIT

for measuring moral judgment do not show statistically significant moral development in nursing students (Lee, 2008; Lee, Kim, & Hong, 2005; Kim et al., 2004). The Korean version of the DIT, translated by Moon in 1986, is widely used in measuring moral development. But the translated version of the DIT reported low reliability in Korea. The Cronbach's alpha of each story reported .48, .65, .79, .60, .47, and .42 in the previous research (Kim et al., 2004). These low reliabilities and the effect of the differences in culture might have increased the measurement error. Moreover, the dated scenarios of the original version of the DIT (Rest, Narvaez, Thoma, & Bebeau, 1999) may not fit in with contemporary medical situations in Korea.

Currently, there are trials that measure ethical/moral sensitivity. Kim et al. (2005) tried to measure nurses' ethical sensitivity with a questionnaire developed by a researcher. Using a moral sensitivity questionnaire developed by Lutzen & Nordin (1994), Han et al. (2007) measured and compared Korean nurses' and nursing students' moral sensitivity. However, moral sensitivity is influenced by each nation's values, norms, and education. Therefore, it is necessary to measure moral sensitivity based on each culture's particular values.

To sum up, there is no evidence to explain nurses' ethical decision-making in specific end-of-life situations in Korea. There is no research that measures the various moral components of moral action in nursing research in Korea. Therefore, this study was designed to contribute to the body of knowledge related to Korean nurses processes of ethical decision-making and moral behavior in nursing practice

Summary

This chapter discussed and criticized the existing studies on nurses' role and responsibility in providing good to patients through making ethical decisions and establishing a

caring relationship. Because nurses' ethical decision-making is complex, a pluralistic view helps to understand the decision-making process and outcomes. Factors influencing nurses' ethical decision-making include nurses' accountability to the code of ethics and nurses' four moral components. However, extant research on end-of-life care did not collect sufficient data on the whole process and outcome of nurses' ethical decision-making. Moreover, factors influencing ethical decision-making were measured on the basis of only one component rather than four components. This lack of findings represents a huge gap in knowledge needed to inform ethical nursing practice.

CHAPTER THREE

METHODS

Introduction

This chapter includes a discussion of the detailed procedures that guided this study, which was designed to conduct a methodological and psychometric evaluation of nurses' ethical decision-making with respect to the End-of-Life Care Scale (NEDM-EOLCS) in Korea. First, this chapter introduces the procedures conducted in this study step. Next, each phase is summarized in relation to the specific research questions and methods chosen.

Procedures

In developing a questionnaire, several scholars have suggested many steps. Aroian et al. (1998) indicated that the process of development and psychometric evaluation of scale has four steps: development of content domain and items, content validation, field testing, and specifying and validating the factor model. DeVellis (2003) provided eight steps for developing measurement scales: determine clearly what it is you want to measure, generate an item pool, determine the format for measurement, have the initial item pool reviewed by experts, consider inclusion of validation items, administer items to a development sample, evaluate the items, and optimize scale length. Walts et al. (2005) suggested seven steps for developing a questionnaire: determine the information to be sought, develop the questions or items, determine the sequence of the questions or items, subject the questionnaire to review, draft the questionnaire and cover letter, pretest the questionnaire, and administer and score the questionnaire.

This research study has modified the process of scale development based on the work of Aroian, Norris, Tran, and Schappler-Morris (1998), Devllis (2003), and Waltz, Strickland, and Lenz (2005) with two phases and seven steps. This research was conducted in two phases: 1) development of content domains and items and 2) initial psychometric evaluation. The purpose of Phase I was to develop content domains and items for NEDM-EOLCS through the following steps: developing content domains based on an integrated review of literature and a preliminary qualitative study; generating a pool of items; determination of content validity; and pilot testing. Through these steps, the NEDM-EOLCS version 3.0 was established. In Phase II, the initial psychometric evaluation of NEDM-EOLCS was performed. Figure 2 shows a flow chart of the detailed phases and steps of the method.

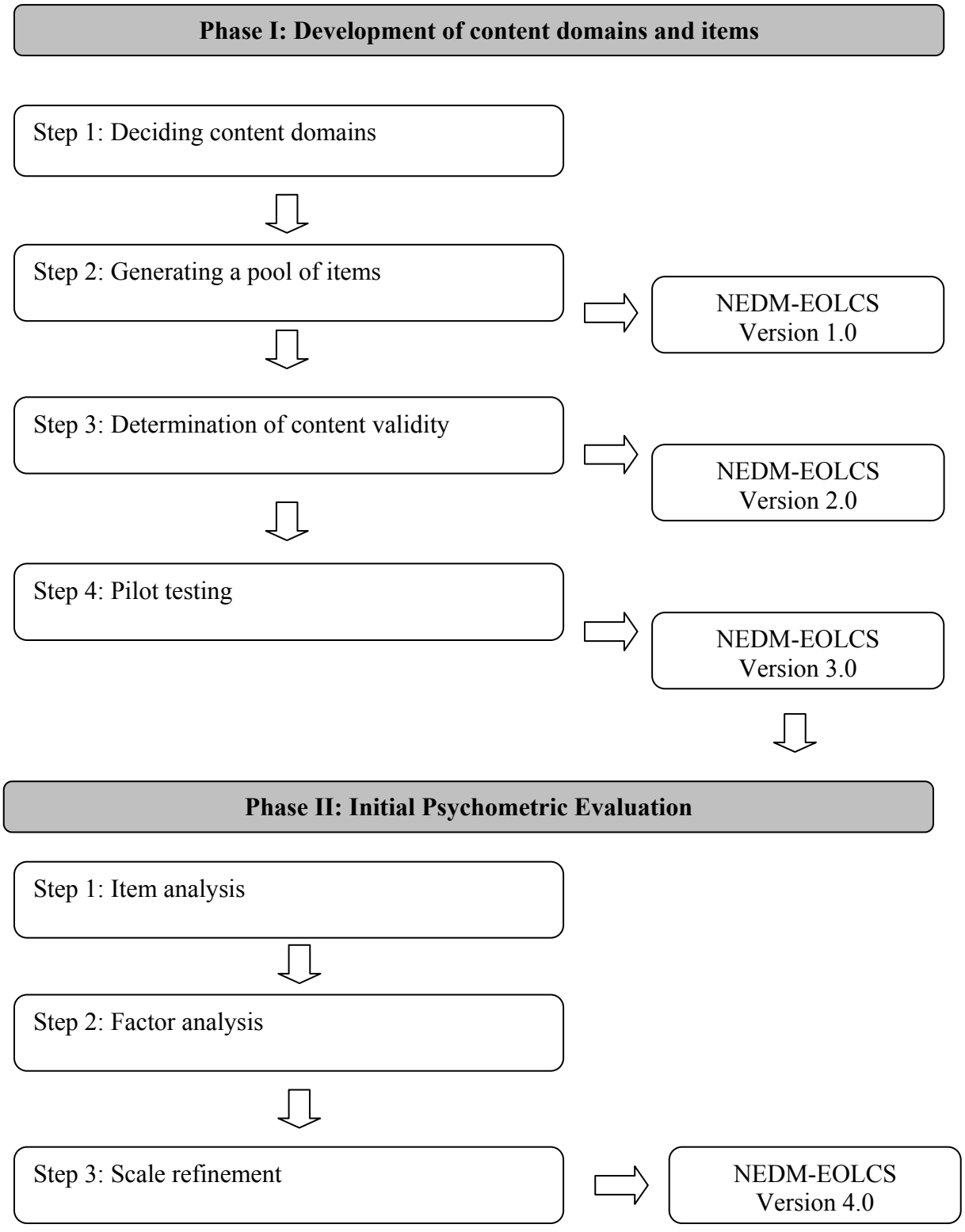

Figure 2. Research flow chart.

Phase I: Development of Content Domains and Items

The purpose of Phase I was to develop content domains and items for the NEDM-EOLCS in Korea through the following four steps: determining content domains, generating a pool of items, determining content validity, and pilot testing. In the beginning, the content domains and items were identified through integrating reviews of prior research and adding the results of a preliminary qualitative, descriptive study. Expert panels reviewed the items for content validity. With the developed items, pilot testing was performed.

Step 1: Deciding Content Domains

To define content domains for measuring nurses' ethical decision-making during end-of-life situations in Korea, both an integrated review of literature and a preliminary qualitative study completed by the author were used. Based on the integrated review of literature, content domains for measuring nurses' ethical decision-making at the end of life were established. Moreover, the content domains were checked and modified by considering them within cultural sensitivity based on the preliminary qualitative research study outcomes.

Step 2: Generating a Pool of Items for NEDM-EOLCS

To generate a pool of items for NEDM-EOLCS, content domains and items for version 1.0 of the NEDM-EOLCS were identified by synthesizing findings from the preliminary qualitative descriptive study with an integrated literature review of prior instruments.

The content domains and items of NEDM-EOLCS version 1.0 identified through integrated review process and qualitative study were translated into English and then back into Korean. Therefore, the NEDM-EOLCS version 1.0 was developed in both Korean and English versions.

Step 3: Determination of Content Validity

The goal of Step 3 was to determine the content validity index (CVI) of the proposed instrument items. Six experts in the field of ethical decision-making regarding end-of-life care were consulted to determine the CVI of the instrument items. In this step, a specific research question was addressed: what is the content validity index (CVI) for NEDM-EOLCS in Korea?

To establish CVI, a panel of experts comprised of three Americans and three Koreans agreed to read and rate the items in the version 1.0 of NEDM-EOLCS according to perceived strength of relevance, clarity, and conciseness. Moreover, the experts offered their own opinions regarding either the content or construct of items. American experts were chosen according to the following inclusive criteria: nurses with experience in end-of-life decision-making, expert in ethics, and doctoral degrees. Korean experts were chosen according to the following inclusive criteria: nurses with doctoral degrees who are bilingual in Korean and English, experts in nursing ethics, and have experience involving end-of-life decision-making.

The Content Validity Index Tool (Lynn, 1986) was used by the expert panel in their review of the NEDM-EOLCS version 1.0 that developed in Step 2. The form asked them to assess using a 4-point rating scale the relevance of each item, clarity, and

conciseness. The CVI for each item was calculated by computing for the item-content validity index, which commonly is used for revising, deleting, or substituting items (Polit & Beck, 2006). I-CVI was calculated to indicate the "proportion of content experts giving item a relevance rating of 3 or 4" (Polit & Beck, 2006, p. 493). At the end of this analysis, the NEDM-EOLCS version 2.0 was established.

Step 4: Pilot Test

The goal of Step 4 was to determine whether the instructions, format, and language of the scale were clear and readily interpretable. Three participants for the pilot test were recruited using a purposive sampling method. Inclusion criteria were the following: Korean nurses working full-time with at least 2 years' experience regarding end-of-life care based on their education level (associate, bachelor, and graduate). NEDM-EOLCS version 2.0 was used with a pilot testing form and general characteristics data sheet. After pilot testing, the format and language were changed to fit into the Korean culture and the NEDM-EOLCS version 3.0 was established.

Phase II: Initial Psychometric Evaluation

Purpose

The purpose of Phase II was to estimate and evaluate the validity, reliability, and factor structure of the instrument. In this phase, the specific research questions were as follows:

1. Is the newly developed instrument reliable in measuring Korean nurses' ethical decision-making regarding EOL?

2. Is the newly developed instrument valid for measuring Korean nurses' ethical decision-making regarding EOL?
3. What is the factor structure of the newly developed instrument?

Sample

According to literature concerned with developing instruments, there are two rules of thumb for calculating sample size. One is for 200 or more subjects (Gorsuch, 1983; Comrey, 1972); the other is for a minimum of five to ten subjects per item (Hatcher, 1994). In this research, a purposive sampling method was used. 300 questionnaires were distributed to nurses in target settings, along with a research flyer. The inclusion criteria for study participation were: a) Korean staff nurses who care for dying patients in general medical-surgical care units, critical care settings in tertiary hospitals, and hospice care units; and b) nurses with more than 2 years' experience in nursing practice.

Finally, questionnaires were returned from 242 subjects (an 81% return rate). After the exclusion of 12 because of systematic missing data, a final population of 230 subjects was used for analysis. The sample size of 230 for tool development was a fair-to-good sample criterion, according to Comrey (1973). The ratio of subjects per item was 3.43. It is not enough to satisfy Hatcher's (1994) strict rule but sufficient to meet Gorsuch's (1983) and Comrey's (1973) standards.

Instrument

As an instrument, the 67 items of the NEDM-EOLCS version 3.0, developed during Phase I, was used. The demographic information sheet also was used to gather

both socio-demographic characteristics (age, education, marital status, and religion) and clinical characteristics (years of clinical experience, specialty, working position, self-reported job satisfaction, and degree of experience with ethical issues).

Data Analysis

The data analysis procedure can be summarized as follows: data was entered into Statistical Package for the Social Sciences (SPSS), program version 15.0. Systematic errors were checked. Demographic characteristics were described with descriptive statistics. To answer the research questions, data analysis was done in three steps: initial item analysis, factor analysis, and scale refinement with reduction and correction.

In Step 1, to determine the initial internal consistency of the NEDM-EOLCS 3.0, Cronbach's coefficient alpha was calculated as a total score from the initial analysis, and then the item-total correlation was evaluated. In Step 2, to determine construct validity of the NEDM-EOLCS and define factor structures, and exploratory factor analysis (EFA) was applied to examine relationships among the various items of the NEDM-EOLCS. In Step 3, based on the findings of the factor analysis, the scale was refined with item reduction and fixing to fit. Finally, the NEDM-EOL version 4.0 was established.

Protection of Human Subjects

This study was conducted after approval of the Institutional Review Board (IRB) of Boston College, Chestnut Hill, Massachusetts, as well as after obtaining letters of permission from sites where data were collected (Appendix 1). The questionnaires were delivered to nurses who met the inclusion criteria in targeted clinical units. Informed consent for nurses to participate in the study was obtained by way of signed permission

slips. Completion of the questionnaire was anonymous and voluntary. The questionnaires were returned in sealed envelopes. Each questionnaire was coded with a number so that the identities of participating nurses were protected.

Summary

The methodological study aimed to develop content domains and items for nurses' ethical decision-making in order to develop an end-of-life care scale (NEDM-EOLCS) and an initial evaluation of psychometric properties in Korea. Three Korean and three American panelists determined the item-content validity index. After pilot testing with three nurses, the NEDM-EOLCS version 3.0 was tested with 230 Korean nurses and analyzed for reliability and construct validity.

CHAPTER FOUR

RESULTS

Introduction

The purpose of this study was to develop an instrument and evaluate initial psychometric properties of nurses' ethical decision-making with respect to the End-of-Life Care Scale in Korea. This chapter discusses the outcome of the process for developing NEDM-EOLCS and results of initial psychometric evaluation.

Phase I: Development of Domains and Items

The purpose of Phase I was to develop an instrument. This part discusses the process and outcome of developing domains and items.

Step 1. Defining Content Domains

Content domains were defined based on an integrated review of literature including codes of ethics, the author's preliminary qualitative study in Korea, and an analysis of both the integrated review of literature and preliminary qualitative study.

First, in the integrated review of literature, the concept of nurses' ethical decision-making was defined as a process to achieve good care at the end of life through nurses' moral behavior. In the process of achieving good care, nurses' professional accountability and nurse's individual moral components are functional to nurses' moral behavior in achieving good care. Next, the International Council of Nurses' code of ethics and the

Korean Nurses' Association's ethical declaration, principles, and guidelines were reviewed. These codes of ethics contain nurses' professional responsibilities in detail.

Second, according to the preliminary descriptive study, Korean hospice nurses defined good care at the end of life as integration and action taken (Kim, 2008b). A qualitative, descriptive study was conducted to define good care at the end of life with 11 Korean hospice nurses. Based on content analysis, four themes were addressed: providing appropriate care for symptom management, being a presence, making good relationships, and tailoring care to individual needs.These four themes well matched nurses' moral behavior at EOL that was derived from the integrated literature review.

Finally, the domains of the newly developed instrument were identified. These consisted of three domains based on the analysis of the integrated review of literature and preliminary study: nurses' professional accountability, nurses' moral components including moral sensitivity, moral reasoning, moral motivation, and moral character; and nurses' moral behavior with respect to EOL care.

Step 2. Generated Items

Within three domains, 95 items were generated based on codes of ethics, the literature review, and preliminary qualitative research outcomes. In the first domain, 27 items concerned with nurses' professional accountability for good patient care were generated based on codes of ethics. In the second domain, 35 items concerned with the nurses' moral components were generated from the literature as follows. This second domain consists of 13 items regarding moral sensitivity, 8 items regarding moral judgment, 9 items regarding moral motivation, and 5 items regarding moral character. In

the third domain, nurses' moral behavior at with respect to end-of-life care, 33 items were derived based on quotations from the preliminary study and literature review.

Items were generated in the Korean language and then translated into English by the researcher and corrected by committee members. The English items were translated back into Korean by doctoral–prepared, bilingual scholars who checked the meaning of the first Korean version. Equivalence between the English version and the back-translated Korean version was established by checking with two bilingual nursing scholars, three expert Korean panels, one bilingual English linguistic scholar, and one Korean literature teacher in a Korean high school who holds a master's degree in Korean. Finally, the NEDM-EOLCS version 1.0 was established in both Korean and English.

Step 3. Content Validity

Three Korean experts and three American experts evaluated the 95 Items of the NEDM-EOLCS version 1.0. All of panel members hold doctoral degrees in nursing and are experts in nursing ethics as well as end-of-life care. The three American panel members work in a hospital setting as clinical leaders or nursing ethicists. The three Korean panel members work at a nursing school.

The content- validity index form was used with a 4 point-scale in relevancy such that 1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, and 4 = very relevant. In addition, clarity (yes or no) and conciseness (yes or no) were evaluated at the same time (Appendix 2). Excellent items evaluated by the expert panel at over.83 of Item-Content Validity Index (Polit, Beck & Owen, 2007) were selected. A total of 77 items were

retained. Table 1, Table 2, and Table 3 show the I-CVI scores for the NEDM-EOLCS version 1.0.

Based on the I-CVI scores, the NEDM-EOLCS version 2.0 was established. The NEDM-EOLCS version 2.0 consisted of two parts: a lead-in question and a response set (Burns & Grove, 2005). The response set was comprised of modified, 6-point semantic differentials, which often are used to distinguish varying degrees of positive and negative attitudes toward a concept (Waltz, Strickland, & Lenz, 2005). The items of the NEDM-EOLCS 3.0 were ordered according to the theoretical perspectives and consideration for describing without obtaining a biased response (Rattray & Jones, 2007). In this research study, the questionnaire would answer how nurses behave morally in EOL situations so that the items concerning nurses' moral behavior appeared in the first part of the scale and items concerning nurses' professional accountability were placed last.

Step 4. Pilot Testing

Three Korean nurses with over the two years' experience, each holding associate's, bachelor's and master's degrees, were recruited to answer the 77 items of the NEDM-EOLCS version 2.0 with pilot testing form. To complete the questionnaire, the time given for respondents to finish was 20-25 minutes. Some unclear items and those with the same content in positive and negative items were eliminated based on pilot testing. After the pilot test, the NEDM-EOLCS 3.0 was established. It consisted of 67 items in three domains (Appendix 3).

Table 1
I-CVI Score of Domain I: Nurses' Professional Accountability (27 Items)

	Item	I-CVI
1	Nurses are responsible for providing the best care for patients at the EOL.	1.00
2	Nurses are responsible for following the physician's orders related to care for patients at EOL.	0.83
3	Nurses are responsible for ensuring that the patient's suffering is relieved at the EOL.	1.00
4	When the nurses' judgment and the physician's conflict related to a patient's care at the EOL the nurse should follow the physician's advice	0.83
5	Nurses are responsible for assisting patients to make the best healthcare decision.	1.00
6	Nurses are responsible for advocating that a patient's individual needs are met.	1.00
7	Nurses should ensure patients receive good care even if the patient is difficult or undesirable.	0.83
8	Nurses are responsible for providing adequate information about the patient's care.	1.00
9	Nurses are responsible for providing adequate explanations to patients about interventions and treatments.	1.00
10	It is acceptable for a nurse to withhold information from a patient when instructed to do so by a physician.	1.00
11	Nurses are responsible for encouraging patients to be involved in the process of their care if the patient is capable	1.00
12	Nurses are responsible for their own practice actions.	1.00
13	Nurses are responsible for recognizing the unethical practice of others and doing something about it.	1.00
14	When patients refuse medical interventions the nurse is justified in no longer providing care.	0.83
15	The nurse should accept the patient's reasoned decision to accept or refuse treatment.	0.83
16	The nurse should support the patient's reasoned decision to accept or refuse treatment.	1.00
17	When a patient is incompetent to make his or her own decisions nurses should help find and support an appropriate substitute decision maker to represent the patient's wishes.	0.67
18	It is the physician's responsibility to find substitute decision-maker for an incompetent patient rather than the nurse.	0.50
19	Nurses own values and beliefs can be used to determine 'good' care for a patient at the end of life.	0.83

Table 1
I-CVI Score of Domain I: Nurses' Professional Accountability (27 Items) (continued)

	items	I-CVI
20	Nurses are responsible for ensuring that patient's who have DNR orders still receive basic nursing care.	1.00
21	Nurses are responsible for advocating that the patient gets what he or she needs even when another nurse, doctor, or family member disagree with the patients considered	1.00
22	Nurses are responsible for advocating that the patient gets what he or she needs even when another nurse, doctor, or family member disagree with the patients considered wishes or desires.	1.00
23	A nurse should refuse to participate in activities which are harmful to the patient.	1.00
24	A nurse should report unethical behavior by following the rules and standards of the institution.	0.67
25	Nurses should be knowledgeable about medical or technological innovations and ensure they are supported in the research literature before using them	0.67
26	Nurses should put the patient's safety as the first priority when she experiences a conflict with others over the patient's care	1.00
27	Nurses should use their clinical judgment in deciding whether a treatment or intervention is appropriate for a patient.	0.83

Table 2
I-CVI Score for Domain II: Nurses' Moral Components at the EOL (35 Items)

	Item	I-CVI
Moral Sensitivity (13 items)		
1	All nursing actions for a patient should be informed by knowledge, skill, experience, and an understanding of that patient's individual needs.	1.00
2	My actions make a difference to the patient who is facing the EOL, and this is meaningful to me.	0.83
3	It is important that I am sensitive to the individual needs of patients and their families.	0.83
4	I empathize with my patients and their situation, and this makes me careful in my actions.	0.67
5	My personal beliefs and values can make me biased towards a particular course of action, so I try to understand what these are before acting.	0.83
6	It is important that I remain focused on the responsibility I have toward my patients.	1.00
7	I recognize what other health professionals' roles and responsibilities are.	1.00
8	When the patient is asking for something that I know is not good for him or her, I am comfortable telling him what he should do.	0.67
9	I try to understand what my patient's best interests are.	0.67
10	When the patient is not competent to make decisions, I know the right person to represent my patient's interests.	0.50
11	I recognize when my patient is not able to make his or her own decision.	0.50
12	My patient can be harmed by nursing actions that go against his or her wishes.	0.83
13	Routine nursing and medical procedures have ethical implications for individual patients.	0.83
Moral Judgment (8 items)		
14	I am able to desire the ethical aspects of a difficult patient situation.	1.00
15	I can identify when an EOL decision is being made that is not in the interests of the patient.	1.00
16	It is the doctor's job to describe the ethical aspects of a difficult patient situation.	0.67
17	Nurses' education and training prepares them to describe the ethical aspects of a difficult situation.	0.83
18	I can separate out the barriers to good care in an ethical conflict.	1.00
19	I know what is needed for the patient to get good care even when there is conflict among those involved.	1.00

Table 2
I-CVI Score for Domain II: Nurses' Moral Components at the EOL (35 Items) (continued)

	Items	I-CVI
20	I know who to go to in order to get help in thinking through a difficult situation.	1.00
21	I encounter complex ethical issues in my setting, and I am able to explain what the issues are to others.	0.67
Moral Motivation (9 items)		
22	I feel compelled to act on behalf of my patients when I see they are not getting their needs or wishes met.	1.00
23	It is too much to expect the nurse to act on the patient's behalf when she is overworked.	1.00
24	When patients and/or their family are thankful for my actions, it encourages me to persist in getting them what they need.	0.83
25	When I feel a connection with the patients, I am more likely to act to meet their needs.	1.00
26	It is my professional responsibility to get my patients' needs met even when this is difficult.	0.83
27	It is meaningful to me to ensure that my patients' needs are met.	1.00
28	The support of my colleagues helps to keep me focused on getting my patients' needs met.	1.00
29	When I am tired or upset, I am still able to focus on meeting my patients' needs in a problematic situation.	1.00
30	My religious calling reinforces my efforts to get my patients what they need.	1.00
Moral Character (5 items)		
31	I actively engage in ethical conflict during end-of-life care and persist until the patient gets what he or she needs.	1.00
32	I keep away from or ignore situations that cause me distress.	1.00
33	I step back from ethical conflicts and try to think through the issue to find a solution.	1.00
34	I actively try to improve my understanding of ethical issues so that I can maximize my effectiveness in resolving them.	0.50
35	I feel strongly that I must try to resolve an ethical problem even if this is risky for me.	0.83

Table 3
I-CVI Score of Domain III: Nurses' Moral Behavior (33 Items)

	Items	I-CVI
1	I try to be a comforting presence for the patients at the EOL even when they do not need hands-on care.	1.00
2	I encourage the patient's family to be with the patient for the final hours.	1.00
3	I try to tailor care to a patient's individual needs.	1.00
4	When I do not know what the best action for a dying patient is, I seek help from others.	0.67
5	I try to help patients at the EOL repair problem relationships they have with important family members or friends.	1.00
6	I ask the patient what he or she needs related to the dying process.	1.00
7	I leave it to the doctor to ask the patient what he or she needs related to the dying process.	0.67
8	I seek out available and current evidence to provide appropriate EOL care to patient.	1.00
9	It is the doctor's responsibility to supply the current evidence about appropriate care for the dying patient.	0.67
10	I try to help patients find meaning in their condition when they are facing the end of their lives.	1.00
11	I use knowledge of what actions I would want for my family member to help provide care for the patient.	0.83
12	I try to mediate between the patients' family and other healthcare providers when there is conflict about the goals of care.	1.00
13	I try to persuade other health care professionals and the patient's family to honor the patient's wishes when they are acting contrary to what the patient wants.	0.83
14	I try to provide education to the patient and family about the purposes of any technology or therapies being used.	0.83
15	It is the doctor's responsibility rather than the nurses' to provide education to the patient and family about the purpose of any technology or therapies being used.	0.83
16	I provide appropriate information about the purpose and goals of withdrawing or withholding treatment.	1.00
17	I defer to the doctor to provide information about the purposes and goals of withdrawing or withholding treatment.	1.00
18	I try to understand the patient's preference regarding end-of-life care and to advocate for these to be heard by those making the decisions.	0.83
19	When the care being provided by other nurses and physicians is not in accord with the current evidence, I point out their mistakes.	0.67

20	I confirm the patient's wishes or preferences regarding DNR/DNI decisions made by family members.	0.83
21	I provide life support including nutrition and hydration for the patients at the end of life.	0.83
22	I provide comfort care rather than aggressive care.	0.83
23	When I know what the preference of the patient is related to DNR/DNI, I ensure that others know before an emergency arises.	0.83
24	I try to ensure that the patient's pain is relieved even if this means using high doses of opioids.	0.83
25	I try to meet with the patient's family regularly and answer their questions.	0.83
26	It is the doctor's job rather than the nurses' to meet regularly with the patient's family to answer their questions.	0.67
27	I set aside my own beliefs and values about what should occur at the EOL when caring for a patient.	1.00
28	When patients and/or their families ask about euthanasia or assisted suicide, I try to understand their concerns.	1.00
29	When patients and/or their families ask about euthanasia or assisted suicide, I tell them that they should not think this way and do not listen to their explanations.	0.67
30	When institutional policies related to EOL practices are inappropriate, I use current evidence to try to change them.	0.83
31	I confront other healthcare providers when their actions are unethical and might cause harm.	0.83
32	I try to ensure that the patient and his or her family are satisfied with their decision-making.	1.00
33	No matter what, I do not completely agree with, I accept and follow the decisions made by the interdisciplinary team.	0.83

Phase II: Initial Psychometric Evaluation

The purpose of Phase II of this study was to describe the initial psychometric evaluation of the NEDM-EOLCS version 3.0. In this section, findings of general characteristics of the sample and data analysis including item analysis and exploratory factor analysis are described. Finally, this section shows how NEDM-EOLCS 4.0 is derived as a result of item refinement.

General Characteristics of the Sample

The socio-demographic characteristics for the sample of the initial psychometric evaluation are provided in Table 4. After eliminating surveys that had systematic missing data, the responses of 230 subjects were analyzed as the sample. The median age of the sample is 30.0 years, while 55.2% of the sample is single. 45% of the participants reported their religion to be protestant. 51.3% of the participants hold a bachelor's degree, and nearly 20% of them hold a master's degree.

The clinical characteristics for the initial psychometric evaluation sample are provided in Table 5. Over half of the sample (52.2%) works in a medical surgical care unit, and just over a quarter (25.7%) works in an oncology care unit. The majority of respondents (74.8%) are staff nurses. The average job satisfaction score is 6.1 on a point scale of 1 to 10 (1: never satisfied and 10: always satisfied). Perceived ethical issues scored an average of 6.2 on a 10-point scale.

With the calculation of Pearson's skewness coefficient, the sample displays skewness in age (skewness coefficient is 0.29) and clinical experience (skewness coefficient is 0.39) of the sample as indicates severe skewness above 0.2 or below -0.2

(Duffy & Jacobsen, 2005, as cited in Munro, 2005, p. 46). However, considering the fact that the majority of nurses who work in a hospital setting are under 29 years old (55.4%), according to a yearbook of nursing statistics (KNA, 2007), it is not necessary to transform data that reflects the actual Korean population of nurses.

Table 4
Socio-demographic Characteristics of Study Sample

General Characteristics		Psychometric Sample (N = 230)
Age	Mean (SD)	31.9 years (± 6.6)
	Median	30.0 years
	Range	23-53 years
Marital Status	Single	127 (55.2%)
	Married	103 (44.8%)
Religion	Catholic	41 (18.1%)
	Protestant	102 (45.1%)
	Buddhism	16 (7.1%)
	None	67 (29.6%)
Education	Associate's	63 (27.4%)
	Bachelor's	118 (51.3%)
	Master's	45 (19.6%)
	Doctorate	4 (1.7%)

Table 5
Clinical Characteristics of Study Sample

General Characteristics		Psychometric Sample (N = 230)
Clinical Experience	Mean (SD)	9.4 years (± 6.5)
	Median	7.0 years
	Range	2.0-33.0 years
Specialty	Oncology Care Unit	59 (25.7%)
	Medical Surgical Care Unit	120 (52.2%)
	Critical Care Unit	15 (6.5%)
	Gynecological Care Unit	20 (8.7%)
	Others	16 (6.9%)
Current Position	Staff Nurse	172 (74.8%)
	Nurse in Charge	34 (14.8%)
	Others	24 (10.4%)
Job Satisfaction (10-point scale)	Mean (SD)	6.1(± 1.7)
	Median	6.0
	Range	2-10
Perceived Ethical Issues (10-point scale)	Mean (SD)	6.2 (± 1.5)
	Median	6.0
	Range	2-10

Step I: Item Analysis

Item analysis proceeded as follows. Initial reliability was estimated. The Cronbach's alpha of the 67-item NEDM-EOLCS 3.0 was .94. Item-total correlations were computed for the 67 items. Items that did not meet the psychometric criteria were eliminated based on a minimum item total correlation of .30. All but 8 items met the minimum level of item-total correlation, with 59 items being retained (Table 6).

Table 6
Dropped Items at below .30 Corrected Item-Total Correlation

	Dropped Items	Item-Total Correlation
PA02	Nurses are responsible for following the physician's order related to care for patients at EOL.	-.309
PA09	It is acceptable for a nurse to withhold information from a patient when instructed to do so by physician.	-.272
PA04	When the nurses' judgment and the physician's conflict related to a patient's care at the EOL, the nurse should follow the physician's advice.	-.174
MM04	It is too much to expect the nurse to act in the patient's behalf when she is overworked.	.027
MC02	I keep away from or ignore situations that cause me distress.	.095
MB22	No matter what I do not completely agree with, I accept and follow the decision made by the interdisciplinary team.	.096
PA13	When patients refuse medical interventions, the nurse is justified in no longer providing care.	.181
MB17	I set aside my beliefs and values about what should occur at the EOL when caring for a patient.	.284

Step II: Factor Analysis

To define the factor structure of the NEDM-EOLCS, Exploratory Factor Analysis (EFA) was conducted using the following steps.

The 59-item NEDM-EOLCS was subjected to Principal Component Analysis (PCA) with varimax rotation and Kaiser normalization. The Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy was .917 and Bartlett's Test of Sphericity was .000. These results are sufficient to meet the criteria to support the use of Factor Analysis (Munro, 2005). Eigenvalues over 1.0 showed 13 factors accounting for 66.3% of variance. However, the Scree plot indicates a more parsimonious, three-component solution (Figure 3). Because this scale initially hypothesized three domains of a nurse's ethical decision-making, professional accountability, moral component, and moral behavior, a three-factor solution was sought in subsequent analysis.

Second, to define factor structure with a three-component solution, various extraction and rotation methods were applied. The best fitting factor structure was identified with principal component analysis, varimax rotation, and Kaiser normalization.

A three-factor solution with 59 items accounted for 44.5% of variance. Component 1 accounted for 22.9%, component 2 accounted for 11.6%, and component 3 accounted for 10.0% of variance. All items are loaded to one or two components over the level of 0.32, which is considered poor loading criteria by Comrey and Lee (1992). However, 12 items are cross-loaded (Tables 7, 8, 9).

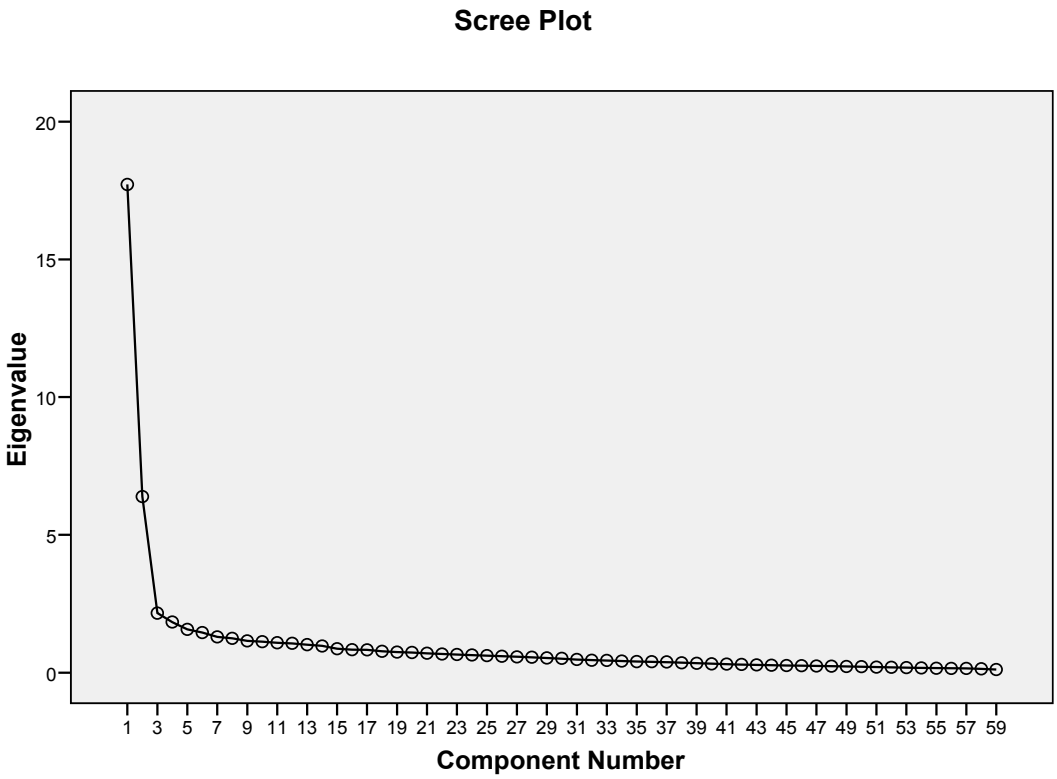

Figure 3. Scree plot.

Table 7
PCA Loading for Domain of Professional Accountability

	Items	Component		
		1	2	3
PA01	Nurses are responsible for providing the best care for patients at the EOL	**.728**	.102	.170
PA03	Nurses are responsible for enduring that the patient's suffering is relieved at the EOL	**.717**	.083	.035
PA05	Nurses are responsible for assisting patients to make the best healthcare decision	**.700**	.156	.065
PA06	Nurses are responsible for advocating that a patient's individual needs are met	**.712**	.112	.132
PA07	Nurses should ensure patients receive good care even if the patients is difficult or undesirable	**.596**	.237	.216
PA08	Nurses are responsible for providing adequate information about the patient's care	**.742**	.033	.121
PA10	Nurses are responsible for encouraging patients to be involved in the process of their care if the patient is capable	**.660**	.102	.113
PA11	Nurses are responsible for their own practice actions	**.746**	-.054	.043
PA12	Nurses are responsible for recognizing the unethical practice of others and doing something about it	**.587**	.225	.077
PA14	The nurse should support the patient's reasoned decision to accept or refuse treatment	**.479**	.225	.040
PA15	Nurses are responsible for ensuring that patients who have DNR orders still receive basic nursing care	**.766**	.026	.119
PA16	Nurses are responsible for assisting patients to receive hospice or palliative care when invasive interventions are no longer desired or effective	**.640**	.006	.075
PA17	Nurses are responsible for advocating that the patient gets what he or she needs even when another nurse, doctor, or family members disagree with the patients considered wishes or desires	**.538**	.177	.077
PA18	A nurse should refuse to participate in activities which are harmful to the patient	**.621**	.159	-.072
PA19	Nurses should put the patient's safety as the first priority when she experiences a conflict with others over the patient's care	**.686**	.116	.078
PA20	Nurses should use their clinical judgment in deciding whether a treatment or intervention is appropriate for a patient	**.494**	.098	.041

Table 8
PCA Loading for Domain of Moral Component

	Items	Component		
		1	2	3
MS01	All nursing action for a patient should be informed by knowledge, skill, experience and an understanding of that patient's individual need.	**.667**	.094	.143
MS02	My actions make a difference to the patient who is facing the EOL.	**.650**	.174	.155
MS03	It is meaningful for me to ensure that I care for patient who is facing the EOL.	**.481**	.254	.276
MS04	It is important that I am sensitive to the individual needs of patients and their family.	**.621**	.176	.238
MS05	My personal beliefs and values can make me biased towards a particular course of action so I try to understand what these are before acting.	**.486**	.180	.316
MS06	It is important that I remain focused on the responsibility I have toward my patient.	**.745**	-.019	.089
MS07	I recognize what are other health professionals' role and their responsibility.	**.529**	.336	.156
MS08	My patient can be harmed by nursing actions that go against his or her wishes.	.208	.380	.013
MS09	Routine nursing and medical procedures have ethical implications for individual patients.	**.742**	.132	.098
MJ01	I am able to describe the ethical aspects of a difficult patient situation.	.194	**.596**	.260
MJ02	I can identify when an EOL decision is being made that is not in the interests of the patient.	.174	**.636**	.127
MJ03	I can separate out the barriers to good care in an ethical conflict.	.278	**.668**	.160
MJ04	I know who to go to get help in thinking through a difficult situation.	.308	**.549**	.066
MM01	I feel compelled to act on behalf of my patients when I see they are not getting their needs or wishes are met.	.362	**.535**	.097
MM02	When patients and or their family are thankful for my actions, it encourages me to persist in getting them what they need.	**.693**	.239	-.040
MM03	When I feel a connection with the patient, I am more likely to act to meet their needs.	**.717**	.187	.105
MM05	It is my professional responsibility to get my patients needs met even when this is difficult.	**.700**	.238	.177
MM06	The support of my colleagues helps to keep me focused on getting my patient's needs met.	**.593**	.296	.025
MM07	When I am tired or upset, I am still able to focus on meeting my patient's needs in a problematic situation.	.188	**.453**	.281
MM08	My religious calling reinforces my efforts to get my patients what they need.	.172	.394	.143
MC01	I actively engage in ethical conflict during the end of life care and persist until the patient gets what he or she needs.	.125	**.727**	.285
MC03	I step back from ethical conflicts and try to think through the issues to find a solution.	.302	**.600**	.254
MC04	I feel strongly that I must try to resolve an ethical problem even if this is risky for me.	.105	.703	.102

Table 9
PCA Loading for Domain of Moral Behavior at the EOL

	Items	Component		
		1	2	3
MB01	I try to be a comforting presence for the patient who is at the EOL even when they do not need hands-on care.	.035	.168	.616
MB02	I encourage the patient's family to be with the patient for the final hours.	.393	.039	.467
MB03	I try to tailor care to a patient's individual needs.	.238	.196	.613
MB04	I try to help patients at the EOL repair problem relationships they have with important family members or friends.	.023	.352	.609
MB05	I ask the patient what he or she needs related to the dying process.	-.045	.400	.578
MB06	I seek out available and current empirical evidence to provide appropriate EOL care to patients.	-.056	.294	.667
MB07	I try to help patients find meaning in their condition when they are facing the end of their lives.	-.054	.435	.664
MB08	I use knowledge of what actions I would want for my family member to help provide care for the patient.	.301	.023	.557
MB09	I try to mediate between the patient's family and other healthcare providers when there is conflict about the goals of care.	.211	.330	.519
MB10	I try to persuade other health care professionals and the patient's family to honor the patient's wishes when they are acting contrary to what the patient wants.	.149	.148	.600
MB11	I try to provide education to patients and families about the purpose of any technology or therapies being used.	.468	-.046	.466
MB12	I provide appropriate information about the purpose and goals of withdrawing or withholding treatment.	.090	.403	.526
MB13	I try to understand what the patient's preference regarding end-of-life care is and to advocate for these to be heard by those making the decisions.	-.115	.524	.554
MB14	I confirm the patient's wishes or preferences regarding DNR/DNI decisions made by family members.	.371	.524	.321
MB15	I try to ensure that the patient's pain is relieved even if this means using high doses of opioids.	.371	.214	.183
MB16	I try to meet with the patient's family regularly and answer their questions.	.150	.441	.517
MB18	When patients and/or their families ask about euthanasia or assisted suicide, I try to understand their concern.	.320	.239	.189
MB19	When institutional policies related to EOL practices are inappropriate, I use current evidence to try to change them.	-.195	.602	.332
MB20	I try to ensure that the patient and his or her family are satisfied with their decision-making.	.111	.478	.306
MB21	I confront other healthcare providers when their actions are unethical and might cause harm.	.130	.492	.234

Third, according to Comrey and Lee's suggestion (1992), items were reloaded using fair loading criteria of over .45. Four items were identified at less than .45 as having poor criteria and subsequently were deleted (Table 10).

Table 10
Dropped Items Loaded Less than .45

	Dropped Items	Loading
MB18	When patients and/or their families ask about euthanasia or assisted suicide, I try to understand their concerns.	.320
MB15	I try to ensure that the patient's pain is relieved even if this means using high doses of opioids.	.371
MS08	My patient can be harmed by nursing actions that go against his or her wishes.	.380
MM08	My religious calling reinforces my efforts to get my patients what they need.	.394

Fourth, with 55 items, 3 factor structures were identified. At the .45 loading level, only one item (MB11), "I try to provide education to the patient and family regarding the purpose of any technology or therapies being used," is cross-loaded between component 1 and component 3. Theoretically, this item was derived from the domain of moral behavior, so it was moved to component 3. In component 1, 28 items including original items regarding professional accountability, all items regarding moral sensitivity, and four items regarding moral motivation were derived. In component 2, all items regarding moral judgment and moral character, four items regarding moral behavior were retained with half of the moral motivation items. In component 3, items regarding moral behavior were retained.

Scale Refinement

The internal consistency reliability of the 55-item NEDM-EOLCS and the three PCA-derived subscales were computed. The total NEDM-EOLCS with 55 items had a Cronbach's alpha coefficient of .95. Component 1, contained 28 items and labeled as "Perceived professional accountability at the EOL," had a Cronbach's alpha of .95 and accounted for 24.1% of variance (Table 11). Component 2 contained 13 items and was labeled as "Moral reasoning and moral agency at the EOL": its estimated Cronbach's alpha was .88 and it accounted for 12.4% of variance (Table 12). Component 3 contained 14 items and was labeled as "Moral practice at the EOL," with a Cronbach's alpha of 0.89 and accounting for 9.9% of variance (Table 13). Finally, the 55 items of NEDM-EOLCS version 4.0 were established with three subscales (Appendix 4).

Summary

During Phase I, three domains for measuring nurses' ethical decision-making at EOL were identified through a literature review and qualitative, descriptive study. The 95 items of the NEDM-EOLCS version 1.0 were established. After validation by a panal of 3 Korean and 3 American experts, 77 items for the NEDM-EOLCS version 2.0 were established by scoring them with an item-content validity index over 0.83. After pilot testing with three Korean nurses, the 67 items of the NEDM-EOLCS version 3.0 were developed by eliminating unclear and redundant items.

In Phase II, the 55-item NEDM-EOLCS 4.0 was established after item and factor analysis of the 67-item NEDM-EOLCS version 3.0; 230 subjects were tested. The factor structure of the NEDM-EOLCS 4.0 was identified with three components: perceived

professional accountability toward end-of-life care, moral reasoning and moral agency, and moral practice at EOL. The internal consistency of the total scale and the three subscales indicated good reliability.

Table 11
PCA Loading for Varimax-Rotated Factor Matrix for Component 1

Component 1: Perceived Professional Accountability at the EOL (28 items) Variance: 24.1% Cronbach's alpha: .95		Loading
PA15	Nurses are responsible for ensuring that patients who have DNR (do-not-resuscitate) orders still receive basic nursing care.	.761
PA11	Nurses are responsible for their own practice actions.	.744
MS09	Routine nursing and medical procedures have ethical implications for individual patients.	.743
PA08	Nurses are responsible for providing adequate information about the patient's care.	.740
MS06	It is important that I remain focused on the responsibility I have toward my patient.	.740
PA01	Nurses are responsible for providing the best care for patients at the EOL.	.727
MM03	When I feel a connection with the patient, I am more likely to act to meet their needs.	.719
PA03	Nurses are responsible for ensuring that patient's suffering is relieved at the EOL.	.716
PA06	Nurses are responsible for advocating that a patient's individual needs are met.	.713
PA05	Nurses are responsible for assisting patients to make the best healthcare decision.	.704
MM05	It is my professional responsibility to get my patients' needs met even when this is difficult.	.703
MM02	When patients and/or their families are thankful for my actions, it encourages me to persist in getting them what they need.	.701
PA19	Nurses should put the patient's safety as the first priority when she experiences a conflict with others over the patient's care.	.688
MS01	All nursing action for a patient should be informed by knowledge, skill, experience, and an understanding of that patient's individual needs.	.663
PA10	Nurses are responsible for encouraging patients to be involved in the process of their care if the patients are capable.	.662
MS02	My actions make a difference to the patient who is facing the EOL.	.652
PA16	Nurses are responsible for assisting patients to receive hospice or palliative care when invasive interventions are no longer desired or effective.	.636
PA18	A nurse should refuse to participate in activities which are harmful to the patient.	.628
MS04	It is important that I am sensitive to the individual needs of patients and their families.	.621
MM06	The support of my colleagues helps to keep me focused on getting my patients' needs met.	.603
PA07	Nurses should ensure patients receive good care even if the patients are difficult or undesirable.	.602
PA12	Nurses are responsible for recognizing the unethical practice of others and doing something about it.	.592
PA17	Nurses are responsible for advocating that the patient gets what he or she needs even when another nurse, doctor, or family member disagrees with the patient's considered wishes or desires.	.544
MS07	I recognize what other health professionals' roles and responsibilities are.	.537
PA20	Nurses should use their clinical judgment in deciding whether a treatment or intervention is appropriate for a patient.	.497
PA14	The nurse should support the patient's reasoned decision to accept or refuse treatment.	.487
MS05	My personal beliefs and values can make me biased towards a particular course of action, so I try to understand what these are before acting.	.483
MS03	It is meaningful for me to ensure that I care for patients who are facing the EOL.	.481

Table 12
PCA Loading for Varimax-Rotated Factor Matrix for Component 2

Component 2: Moral Reasoning and Moral Agency (13 items) Variance: 12.4% Cronbach's alpha: .88		Loading
MC01	I actively engage in ethical conflict during end-of-life care and persist until the patient gets what he or she needs.	.731
MC04	I feel strongly that I must try to resolve an ethical problem even if this is risky for me.	.692
MJ03	I can separate out the barriers to good care in an ethical conflict.	.681
MJ02	I can identify when an EOL decision is being made that is not in the interests of the patient.	.640
MB19	When institutional policies related to EOL practices are inappropriate, I use current evidence to try to change them.	.636
MC03	I step back from ethical conflicts and try to think through the issues to find a solution.	.615
MJ01	I am able to describe the ethical aspects of a difficult patient situation.	.606
MB14	I confirm the patients' wishes or preferences regarding DNR/DNI decisions made by family members.	.552
MJ04	I know who to go to to get help in thinking through a difficult situation.	.536
MB20	I try to ensure that the patient and his or her family are satisfied with their decision-making.	.517
MM01	I feel compelled to act on behalf of my patients when I see they are not getting their needs or wishes met.	.510
MB21	I confront other healthcare providers when their actions are unethical and might cause harm.	.499
MM07	When I am tired or upset, I am still able to focus on meeting my patients' needs in a problematic situation.	.458

Table 13
PCA Loading for Varimax-Rotated Factor Matrix for Component III

Component 3: Moral Practice at the EOL (14 items) Variance: 9.9% Cronbach's alpha: .89		Loading
MB07	I try to help patients find meaning in their condition when they are facing the end of their lives.	.624
MB06	I seek out available and current empirical evidence to provide appropriate EOL care to patients.	.623
MB01	I try to be a comforting presence for patients who at the EOL even when they do not need hands-on care.	.619
MB03	I try to tailor care to a patient's individual needs.	.608
MB10	I try to persuade other health care professionals and the patient's family to honor the patient's wishes when they are acting contrary to what the patient wants.	.595
MB04	I try to help patients at the EOL repair problem relationships they have with important family members or friends.	.577
MB08	I use knowledge of what actions I would want for my family members to help provide care for the patients.	.574
MB05	I ask the patient what he or she needs related to the dying process.	.526
MB12	I provide appropriate information about the purposes and goals of withdrawing or withholding treatment.	.522
MB13	I try to understand what the patient's preference regarding end-of-life care is and to advocate for these to be heard by those making the decisions.	.505
MB09	I try to mediate between the patient's family and other health care providers when there is conflict about the goals of care.	.492
MB11	I try to provide education to the patient and family about the purpose of any technology or therapies being used.	.489
MB02	I encourage the patient's family to be with the patient for the final hours.	.477
MB16	I try to meet with the patient's family regularly and answer their questions.	.477

CHAPTER FIVE:

DISCUSSIONS AND IMPLICATIONS

Introduction

This chapter provides an overview of the study and discussion of the findings. Following this, implications in terms of nursing knowledge development, education, practice, research, and policy are addressed. Finally, the limitations of this research and recommendations for future studies are discussed.

Overview of the Study

The purpose of this methodological study was two-fold: to develop domains and items for measuring nurses' ethical decision-making around end-of-life care, and to evaluate initial psychometric property.

During Phase I, the domains for measuring nurses' ethical decision-making with respect to end-of-life care were identified through an integrated review of literature and preliminary qualitative research findings in Korea. The three domains included nurses' professional accountability, nurses' four moral components, and nurses' moral behavior. Within three domains, a pool of 95 items for the NEDM-EOLCS was generated based on the literature and qualitative study findings. With three Korean and three American experts, the contents were validated with item-content validity index scores over 0.83. After content validation, the 77 items for the NEDM-EOLCS 2.0 were pilot tested for

readability with three Korean nurses, and then the 67 items for the NEDM-EOLCS 3.0 were established.

During Phase II, initial psychometric evaluation was performed with a sample of 230 Korean nurses. Based on item analysis, 59 items rated over .30 of the item total correlation were retained. With exploratory factor analysis applying principal component analysis with varimax rotation, 4 items with poor loading criteria were dropped. 55 items for the NEDM-EOLCS 4.0 were established with three components. These were labeled "perceived professional accountability," "nurses' moral reasoning and moral agency," and "nurses' moral practice at the EOL." The Cronbach's alpha for the NEDM-EOLCS 4.0 with 55 items was.95, and the Cronbach's alpha for the three subscales were.95, .88, and .89, respectively.

Discussion of the Findings

Psychometric Evaluation

The reliability of this newly developed instrument was established.. The coefficient alpha of the NEDM-EOLCS version 4.0 with 55 items was .95. This is sufficient to establish reliability (Devon et al., 2007). The three subscales had coefficient alphas of .95, .88, and .89, respectively. The first extracted subscale, which consisted of the 28 items regarding perceived professional accountability, was also at the level considered ideal for establishing reliability by Devon et al. (2007). However, both the second extracted subscale (moral reasoning and moral agency) and the third subscale (moral practice) were not sufficient to achieve an ideal level but are considered

acceptable levels for new scales as described by DeVellis's (2003) criteria, which set the minimum acceptable level as a .70 coefficent alpha.

Regarding the contents of this newly developed instrument, the content validity was established through item-content validity index (I-CVI), achieving .83 upon review by six expert panel members. According to Polit, Beck, an Owen (2007), an I-CVI of .67 generated by a six-member panel is considered fair, while .83 and above is considered excellent. Therefore, all of the items retained in that NEDM-EOLCS that were over.83 I-CVI can be validated as excellent in terms of relevance according to Polit, Beck, and Owen's (2007) criteria.

As noted in chapter four, construct validity was established with exploratory factor analysis. According to Devon et al.'s (2007) criteria, the accepted standard includes Eigenvalues > 1.0, factor loadings >.40, and approximately five subjects per variable or number of subjects. In this research, Eigenvalues of three factor solution were 2.161 and factor loadings were >.45. Thus, these easily satisfy Devon et al.'s (2007) criteria. While the ratio of subjects per variable was 3.43, the fact that there were 230 subjects is considered good, according to Comrey's (1973) criteria. Therefore, this newly developed tool can be considered to have good construct validity.

Principal Component Analysis-Derived Concepts

Perceived Professional Accountability

As a result of this research study, moral sensitivity was merged with professional accountability as the first component of nurses' ethical decision-making. Combining the items related to professional accountability and moral sensitivity led to this component's

being labeled "perceived professional accountability." In ethical decision-making resulting in moral action, ethical and moral sensitivity has been reported to be an essential first part of the overall cognitive process—if one does not recognize that a problem exists, one will not embark on the process—although it is not sufficient for moral agency in and of itself (Rest, 1983; Lutzen et al., 2006; Jordan, 2007; Weaver, 2007). Originally, Rest's (1986) four-components model supported the identification of moral sensitivity with moral reasoning, motivation, and moral character as comprising the complete process of moral agency. However, in the nursing profession, several scholars have asserted the importance of ethical/moral sensitivity as a part of moral responsibility. Lutzen et al. (2006) reported that moral sensitivity is preconditioned by an awareness of the moral significance of one's actions. Their instrument, the moral sensitivity questionnaire (MSQ), was consisted of three factors: "a sense of moral burden, moral strength, and moral responsibility" (Lutzen et al., 2006, p. 192). Weaver et al. (2008) pointed out that ethical sensitivity can be found in professional practice through nurses' perceptions of how their professional role places responsibilities upon them. Therefore, in nurses' ethical decision-making, perceived professional accountability may play a key role in regard to nurses' action-taking. This research finding supports the notion that moral sensitivity is related to an understanding of one's professional responsibility, and together these function as the first part of nurses' ethical decision-making.

Moral Reasoning and Moral Agency

Next, moral reasoning and moral agency were addressed as the second component of this developed instrument. Originally, the second domain was designed with moral

components including moral sensitivity, moral reasoning, moral motivation, and moral character. The second component derived from the principle component analysis (PCA) consisting primarily of items concerned with moral reasoning or moral character and some items concerned with moral motivation and moral behavior. Some items that originally were in the moral behavior section now are included with moral agency. Because moral character is defined as perseverance in having the courage to serve a moral goal through moral action, items, moved from moral behavior to moral agency into the second component could be understood as being equivalent to moral character. Examples of moved items included the following:

- "I confirm the patients' wishes or preferences regarding DNR/DNI decisions made by family members." (MB14)
- "When institutional policies related to EOL practices are inappropriate, I use current evidence to try to change them." (MB19)
- "I try to ensure that the patient and his or her family are satisfied with their decision-making." (MB20)
- "I confront other health care providers when their actions are unethical and might cause harm." (MB21)

Because EOL situations can be very complex with respect to decision-making, it is necessary to analyze situations and consider alternative courses of action using a moral reasoning process. According to Devlin and Magill (2006), developing a process for ethical decision-making through "clarification of the feasible options, determination of the best solution available, and implementation of the decision and subsequent evaluation" (p. 504) helps to resolve ethical dilemmas or problems. This approach is

widely supported and used both in nursing and in clinical ethics situations. Nurse scholars have noted that nurses also bring to bear knowledge and skills from their nursing education and clinical experiences to the decision-making process in addition to using analysis and knowledge of the needs and desires of patients and their families (Grace, 2009). At the EOL, nurses' ethical reasoning can clarify complex situations; determine barriers, resources, and the best solution; and implement decisions. This process is all about moral reasoning. Items such as: "I am able to describe the ethical aspects of a difficult patient situation" (MJ01) and "I can separate out the barriers to good care in an ethical conflict" (MJ03) can be matched with moral reasoning.

Moral agency can be defined as the ability "to recognize, deliberate/reflect on, and act on moral responsibilities" (Peter & Liaschenko, 2004, p. 221). The concept of moral agency requires nurses to use clinical wisdom, which is an essential foundation of good care with their moral identity as professionals in order to engage in effective action (Haggerty & Grace, 2007). According to Reynolds and Ceranic (2007), moral behavior is affected by both moral judgment and moral identity, which works as "a self regulatory mechanism" (p. 1611) for behavior. To sum up, nurses as moral agents at the EOL recognize their obligation and responsibility reflect on the situation with their clinical wisdom to achieve good care for patients and act with moral courage for the good of patients. Items such as "I feel strongly that I must try to resolve an ethical problem even if this is risky for me" (MC04) and "I actively engage in ethical conflict during end-of-life care and persist until the patient gets what he or she needs" show the concept of nurses' moral agency at the EOL.

Moral Practice

Finally, moral practice as a part of good care at the EOL was addressed as the last component of nurses' ethical decision-making. Moral practice at the EOL can be defined as answering the following questions: where does nurse find the goal of care? How does the nurse get there? Then what does the nurse do?

According to Gastmans et al. (1998), nursing is considered a moral practice that has three components: a caring relationship, caring behavior, and good care. Tarlier (2004) asserted that the moral foundation of nursing derives from a personal and disciplinary moral sense and a responsive nurse-patient relationship.

In this research study, items such as "I ask the patient what he or she needs related to the dying process" (MB05) and "I try to understand what the patient's preference regarding end-of-life care is and to advocate for these to be heard by those making the decision" (MB13) illustrate the caring relationship and behavior fostering good care through a responsive nurse-patient relationship. The item "I try to persuade other health care professionals and the patient's family to honor the patient's wishes when they are acting contrary to what the patient wants" represents an example of professional advocacy (Grace, 2001), which derives from the understanding that there are moral responsibilities associated with professional practice. This understanding can be thought of as a disciplinary moral sense. To sum up, the moral practice of good care at the EOL includes caring behavior with responsive nurse-patient relationships informed by the disciplinary moral sense.

Implications

The implications of these findings for Korean nursing education, practice, and research specifically and for nursing education, practice, and research more broadly are described below. The findings of this research have added to nursing's body of knowledge by supporting previous studies and adding new insights. Implications for nursing knowledge development, nursing education, nursing practice, nursing research, and nursing policy-making are discussed in the following sections.

Nursing Knowledge Development

In terms of nursing knowledge development, this study serves as an example of how a significant question of nursing practice can be researched via a rigorous process of tool development and testing that yields insights for further study. The development of the tool proceeded from the recognition of a problem within a given culture and area of practice through an exploration of appropriate philosophical and theoretical foundations, prior studies, and the design of a qualitative study that revealed culture specific issues and resulted in culturally appropriate items. Additionally, the psychometric testing process revealed that ethical sensitivity and professional responsibility are inseparable concepts. While this has been suggested in the nursing ethics literature, this study provides empirical support. Also, this research gives an example of applying Rest's (1986) four-component model in nursing in a way that sheds new light on the interrelated relationship of the components.

First, this research offers a way to develop nursing knowledge in ethics. As Carper (1978) pointed out in discussing the pattern of ethical knowing, this research is

focused on nurses' obligation and voluntary actions with respect to end-of-life care. Also, as Chinn and Kramer (2008) reported related to processes for ethical knowledge development, this research questioned what nurses believe to be right and reasonable with respect to end-of-life care. This research adds to disciplinary knowledge about how nurses justify and clarify values in nursing in end-of-life care situations. While the tool was used with Korean nurses, it has been argued that Korean nurses have not been viewed as having the same autonomy of practice as their Western counterparts (Kim et al., 2007), although the codes of ethics in Korea and the U.S. articulate similar responsibilities. Thus, a culturally appropriate version of the tool could be used in various countries and settings to further develop this area of knowledge. According to this research finding, nurses' moral behavior, voluntary action to achieve good care at the end of life could be justified with value clarification and value analysis of both professional accountability and moral components for good care at the end of life.

Second, this research provides an example of a consistent continuum in philosophy, concept, and measuring items. As discussed in chapter two, the concepts of professional accountability, moral components, and moral behavior are derived from theories in moral philosophy about what constitutes good action and under which conditions. A variety of moral theories such as deontology (good actions come from acting according to one's duty), virtue ethics (good actions are taken by those who cultivate good character), and teleology (good actions are those that have good consequences) have been proposed by different philosophers as the most appropriate theory to use (Grace, 2009). However, the theories generally have been seen as incommensurable with each other. That is, one cannot be both a deontologist and a

teleologist. However, when professionals' goals and obligations provide the focus of good action, then aspects of these theories may well apply depending on a given situation. For nursing, then, duties are important, character is important, and consequences are important, but so is an understanding of the patients' needs, and a desire to meet these needs (caring ethics) provides the impetus for action (Grace, 2009). Based on the philosophical and conceptual underpinnings used to explain nurses' ethical decision-making with respect to end-of-life care, measuring items are generated from each domain (see Figure 4).

Thus, this research provides an example of "consilience"(Wilson, 1998; 2001) in nursing ethics. Consilience is the "jumping together of knowledge by integrating factors and facts-based theory from different disciplines in order to develop a common language and comprehensive explanatory framework" (Valone, 2005, p. 189). Because it is hard to explain ethical decision-making with only one particular perspective, it is necessary to integrate various perspectives for explaining ethical decision-making; as McCarthy (2006) asserted, nursing ethics needs to take a pluralistic view. This research gives an insight into how nurses work with integrated perspectives from deontology, teleology, and virtue ethics along with caring ethics. Figure 4 illustrates a consistent continuum from philosophy to measuring items vertically and the consilience of multi-dimensions for nurses' ethical decision-making with respect to end-of-life care horizontally.

Fourth, this research supports previous work in nursing related to the importance of caring ethics for integrating knowledge. Each philosophical underpinning, such as deontology, virtue ethics, and teleology, along with caring ethics, may help us to understand nurses' ethical decision-making process. The caring relationship provides a

focus for perceiving professional accountability, using moral reasoning and agency, and persevering to achieve the moral course of action that facilitates his or her patient's good. According to Milton (2004), nursing ethics has philosophical underpinnings embedded within the nursing discipline and in nursing theories that characterize the nature of nursing and what nurses ought to do from nursing perspectives. Caring as involved engagement with the patient (or family) in order to discover the patient's real needs along with an understanding of their professional duty (deontology) causes nurses' accountability to move beyond principles or rules to do good for patients. Caring, along with virtue ethics, helps nurses to persevere in getting the patient what he or she needs, as Allmark asserted (1998). Caring, along with an understanding that good consequences matter (teleology), helps nurses do what is right for the patient.

Fifth, this research attempts to apply Rest's (1986) four-component model in nursing. Bebeau (2002) reported that the four-components model could enhance understanding of moral functioning in professional education better than a defining issues test focused only on moral reasoning. Rushton and Penticuff (2007) agreed that Rest's (1986) model could analyze the role of the ethical practitioner from perception to action taken in critical care nursing. This instrument was developed and tested based on Rest's (1986) four-components model as a framework.

Sixth, the findings derived by principal component analysis provide a revised model for exploring Korean nurses' ethical decision-making at EOL that is sensitive to cultural nuances. Compared to earlier conceptual frameworks identified through an integrated review of literature, the PCA-derived framework may provide insights allowing Korean nurses to engage in moral practice based on perceived professional

accountability, moral reasoning, and moral agency for good care at the EOL. Compared to the original four cognitive components of moral agency postulated by Rest (1986), moral sensitivity and a sense of professional responsibility together seem crucially important in Korean nurses' ethical decision-making process. Figure 5 presents a modified model of nurses' ethical decision-making derived from the study findings. For the future, a confirmatory factor analysis with a different sample is recommended to evaluate which model best describes Korean nurses' ethical decision-making around end-of-life care.

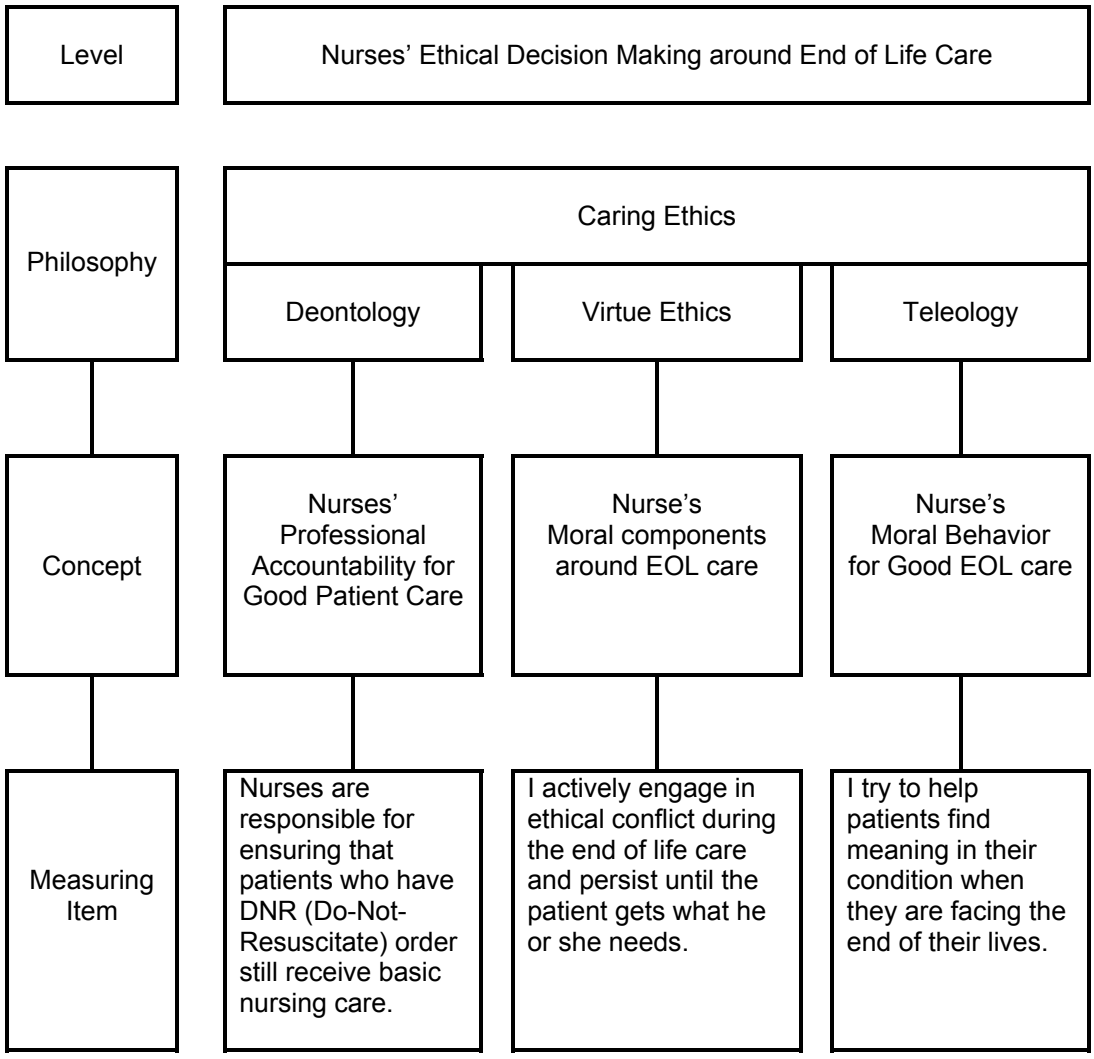

Figure 4. Domains and items through integrated review and preliminary qualitative study.

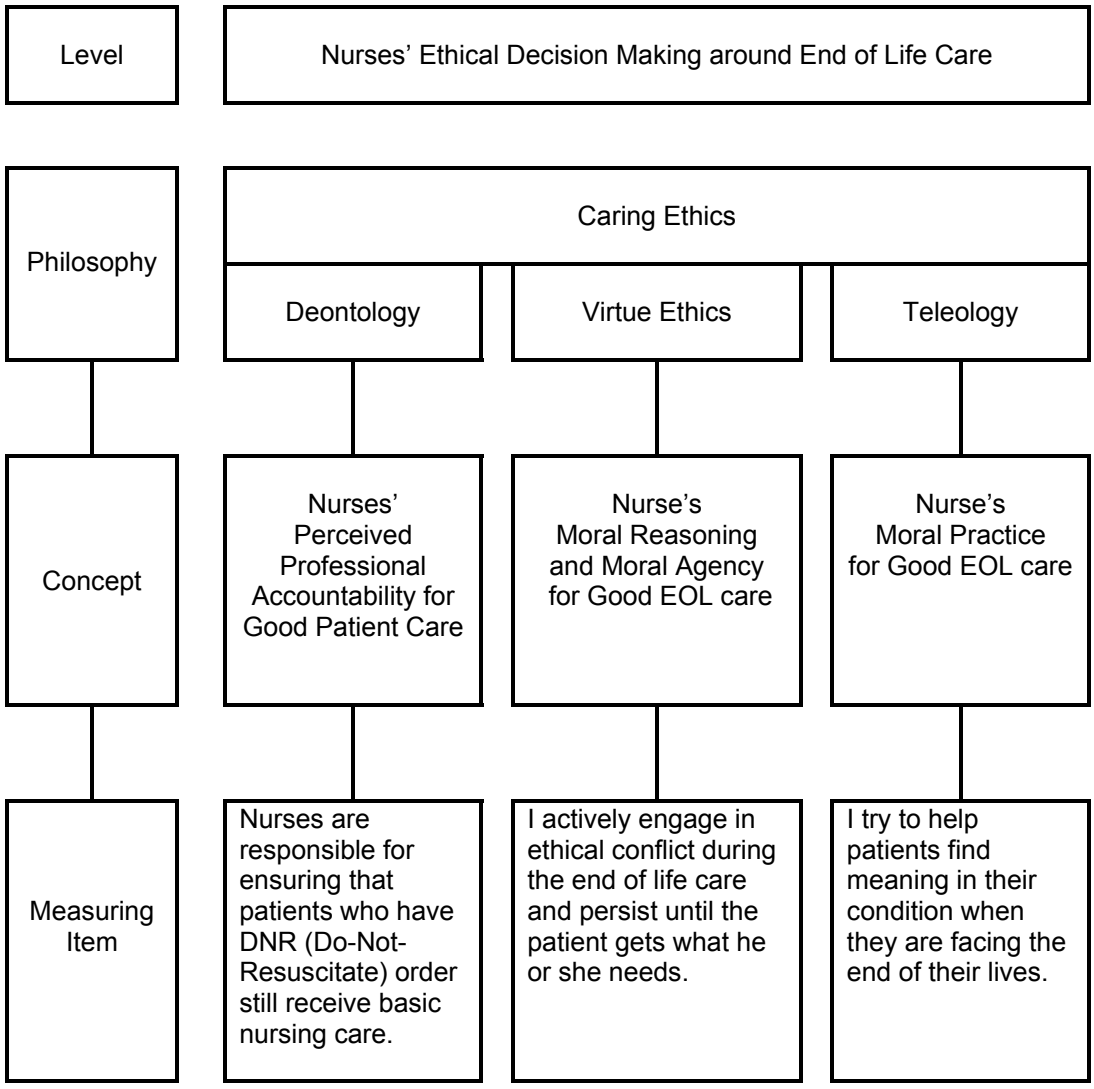

Figure 5. Integrated knowledge of components of end-of-life care.

Nursing Education

This research provides implications related to how the nursing discipline should conceptualize appropriate educational goals, content, and competencies for teaching nursing ethics. The goals of teaching nursing ethics include helping the nurse or nursing student enhance moral decision-making and behavior in order to provide high-quality care to their patients (Holland, 1999; Volker, 2003). The question of which content should be covered in nursing education as well as in nursing ethics education in order to achieve professional goals is raised as a result of this research as well as in other studies. Additionally, what characteristics should be fostered? In this research, perceived professional accountability and merged items regarding professional accountability and moral sensitivity accounted for the first component with 24.1% of variance, and the second component, moral reasoning and moral agency, accounted for 12.4% of variance in explaining nurses' ethical decision-making. This means that teaching health care ethics needs to be concerned with all of the following: increasing the students' understanding of their professional goals and responsibilities, emphasizing the idea that all practice has ethical implications (moral sensitivity), and giving the students practice in moral reasoning about difficult situations using the idea of professional responsibility as a basis.

Each item of this instrument could be useful for evaluating nurses' or nursing students' competencies in ethical practice with respect to end-of-life care. The educational competencies may create a bridge between education and practice, although there are also implications for continuing nursing education. Because competency is focused on action or behavior (Tilley, 2008), the third component, nurses' moral practice

for good care at the EOL, can be matched to evaluate competencies for EOL care education or nursing ethics education.

Despite the fact that most schools in Korea provide nursing ethics education in their curriculum either through independent classes or parts of the curriculum using lectures in the classroom (Lee et al., 2001), evaluations of the use of moral judgment did not show the effect of ethics education in nursing (Kim et al., 2004; Lee, Kim, & Hong, 2005). As Jaeger (2001) recommended for U.S. nursing ethics education, nursing and other educators involved in the ethics education of nurses need to be more concerned about emphasizing the development of moral sensitivity as a component of moral reasoning in Korea than they have been. Eventually, this instrument may give nursing education in Korea the impetus for conceptualizing appropriate goals, content, and competencies for nursing students in order to fortify nurses' moral agency on behalf of their patients.

Nursing Practice

This research highlights the link between nursing ethics and nursing practice, especially within the context of end-of-life care and nurses' involvement in ethical decision-making. Have and Clark (2002) pointed out that there are interactions between ethics and palliative care as "ethics in palliative care" and "ethics of palliative care" (p. 3). The former refers to ethics as a part of palliative care, and the latter refers to ethics in palliative care through reflection and analysis. As Have and Clark (2002) asserted, nursing practice at the end of life is inevitably fraught with ethical issues. Understanding the nature of professional responsibilities and having the skills to be involved in decision-

making on behalf of patients is a moral imperative. Nursing ethics in EOL care provides a way to solve the problem of ethical conflicts. End-of-life nursing ethics also gives nurses insight into the meaning, nature, and goals of EOL care.

Next, this research gives some clues about which values are involved in reaching ethical decisions. Nursing and related ethics literature have explained how nurses' ethical decision-making relies on various ethical decision-making models. Fry (1994) used the nursing process for decision-making. Her ideas include: the story and context of the ethical problem, the significance of the values pertinent to the problem, the meaning of the conflict to involved individuals, and potential solutions to the problem. Cameron's (2000) "value, be, do" model helps answer the following questions: what should I believe, who should I be, and what should I do? Compared to existing models of nurses' ethical decision-making focused on the way to get there, the conceptual framework of this research provides problem-solving laden with values.

Moreover, the findings of this research may imply how Korean nurses act in a positive way at the EOL with respect to ethical issues and problems. Existing nursing knowledge regarding end-of-life situations in Korea has caused nurses to experience moral distress (Yoo, 2004; Yoo & Park, 2005). In daily nursing activity, nurses should take action and move forward for their patients' good. However, in Korean nursing literature, it is hard to capture how Korean nurses engage in patient care, although the distress situation has been identified with respect to end-of-life care. Recently, Breakey's (2007) grounded theory about "optimizing stewardship" explained what characteristics allow nurses to act morally despite obstacles. Her study revealed how taking informed action can help alleviate the distress felt when one perceives that one cannot do what one

feels one should. The concept of moral agency, the ability to perceive what actions should be taken and to persevere in carrying out the action (Rest et al., 1986), requires all of the components: sensitivity, motivation, moral character, and moral behavior. Moral agency is an obligation of the nurse, but the nurse needs help to overcome obstacles. While not all nurses understand that their practice incurs an ethical obligation, some do. The following items are typical examples: "I actively engage in ethical conflict during end-of-life care and persist until the patient gets what he or she needs" and "I feel strongly that I must try to resolve an ethical problem even if this is risky for me."

Nursing Research

In terms of nursing research, the newly developed instrument with its established reliability and validity may help Korean nursing describe the extent of nurses' ethical decision-making. Also, a descriptive correlation study can be conducted with this instrument in order to identify factors affecting ethical decision-making regarding end-of-life care among Korean nurses. Those outcomes of descriptive and descriptive correlation study may give Korean nursing a direction for intervention study.

Related to educational interventions, this instrument may be used to confirm the effect of educational interventions in nursing. In Korea, as concern about EOL has increased, various educational programs regarding hospice and palliative care have been started. The length of these programs ranges from 61-hour to 520-hour courses (Choi, Yoo, Kim, & Lee, 2006). Research regarding the effect of various educational programs for EOL care may apply with this instrument.

Recently, there has been a movement toward undertaking outcome research that is focused on the end results of patient care. This movement is supported by the policy-makers. As the concept of "nurse dose"—that is, the amount of nursing care supplied—gave the nursing discipline the insight that nurses' knowledge, skill, and expertise are all implicated in improved health care outcomes (Brooten, 2006), so too in the hospice and palliative care area is it well known that the effect of healthcare providers may change patient outcomes. However, there is little empirical evidence related to what is known about how "nurse dose affects patients' outcomes related to end-of-life care. With this instrument, nursing research can be conducted to see how nurses' moral practice is related to good patient outcomes.

Nursing Policy Development

In terms of nursing policy development, this research implies policy development for end-of-life care as well as for nursing ethics. For end-of-life care, this research agenda is well-matched with high-quality palliative care provided by the National Consensus Project guidelines (NCP, 2009). NCP (2009) guideline 8.2 says, "the palliative care program is aware of and addresses the complex ethical issues arising in the care of people with life-threatening debilitating illness." In Korea, there are no position statements or standards by consensus from healthcare providers in hospice and palliative care area yet. This research may provide a basis for position statements for Korean hospice and palliative nurses as well as health care policy concerned with providing good care in end-of-life care situations by consensus of related healthcare providers.

For nursing ethics, the items regarding professional responsibilities were addressed based on Korean nurses' ethical guidelines.

Limitations

This study has some limitations as follows. In terms of psychometrical evaluation, this research did not address stability and criterion validity. The stability of an instrument often is evaluated with test-retest reliability. After the first data were collected, ethical issues with respect to end-of-life decisions have become of greater concern in Korea. The 79-year-old lady was removed from the ventilator, but she lived without it for over two months. Because of the halo effect, this research did not address test-retest reliability. There is no well-matched instrument for measuring concurrent validity. However, the Moral Sensitivity Questionnaire (MSQ) is a possible instrument for predicting validity. This MSQ has been translated into Korean but has not yet reported psychometric properties. The moral distress scale developed by. Yoo (2006), one of the members of the Korean panel, has 60 items that may measure discrimination validity. However, because of the respondents' burden, it did not. For future research, stability and criterion validity should be considered for further evaluation. Moreover, it is necessary to confirm the factor structures. This study applied exploratory factor analysis with a fair-to-good sample, but future confirmatory factor analysis is recommended with a large sample size . That might contribute much more to building nursing knowledge.

Summary

This chapter summarized the study briefly, and then research outcomes were discussed in terms of psychometrical property. The implications of this study, including

nursing knowledge development and nursing education, research, practice, and policy development, were discussed. Finally, this chapter noted the limitations of the study and offered recommendations for future research.

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APPENDICES

List of Appendices

Appendix 1.

Institutional Review of Board Permission

Appendix 2.

Example of Content Validation Index (CVI) Form (English/Korean)

Content Validity Index Tool For
Nurses' Ethical Decision Making around End of Life Care Scale
(NEDM-EOLCS) version 1.0

Sanghee Kim, RN., PhD(c)
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Dear reviewer,

Thank you for participating in my panel of expert to determine the content validity of 'Nurses' Ethical Decision Making around End of Life Care Scale (NEDM-EOLCS)'. This instrument was developed with 95 items to measure nurses' ethical decision making around end of life care particularly in Korea. It was based on qualitative descriptive study in Korea, nurses' code of ethics, and integrative review of literature. This scale consists of three domains: 1) nurses' accountability at the end of life (EOL), 2) nurses' moral components including moral sensitivity, moral judgment, moral motivation, and moral character, and 3) nurses' moral behavior at the end of life.

Please evaluate each item list below about relevancy, clarity, and conciseness. After determination, please check and save those results and e-mail me back to SKIM52@PARTNERS.ORG or sanghee.kim.1@bc.edu. Also please feel free to comment for establishing better instrument.

Sanghee Kim, RN., PhD(c)

Sanghee Kim

Domain I: Nurses' Professional Accountability for Good Patient Care (27 items)

Nurses' professional accountability for good patient care is a sense of what nurses should do as healthcare professionals to provide good care for the patient.

27 Items for Nurses' Accountability for good patient care	Relevancy				Clarity		Conciseness	
	1= Not relevant 2= Somewhat Relevant 3= Quite Relevant 4= Very relevant				Y=Yes N=No		Y=Yes N=No	
	1	2	3	4	Y	N	Y	N
1. Nurses are responsible for providing the best care for patients at the EOL.								
2. Nurses are responsible for following the physician's orders related to care for patients at EOL.								
3. Nurses are responsible for ensuring that the patient's suffering is relieved at the EOL.								
4. When the nurse's judgment and the physician's conflict related to a patient's care at the EOL the nurse should follow the physician's advice.								
5. Nurses are responsible for assisting patients to make the best healthcare decision.								
6. Nurses are responsible for advocating that a patient's individual needs are met.								
7. Nurses should ensure patients receive good care even if the patient is difficult or undesirable.								
8. Nurses are responsible for providing adequate information about the patient's care.								
9. Nurses are responsible for providing adequate explanations to patients about interventions and treatments.								

Comments

말기환자를 돌보는 간호사의 윤리적 의사결정 측정도구 Version 1.0
전문가 타당도 검증 (국문)

안녕하세요? 보스턴 대학 간호학과 박사과정에 재학 중인 김상희 입니다.

바쁘신 중에도 '말기환자를 돌보는 간호사의 윤리적 의사결정 측정도구'개발을 위한 전문가 타당도 검증에 참여해주시기로 수락해주신 전문가 여러분께 감사를 드립니다. 이 도구는 특별히 한국에서 말기환자를 돌보는 간호사의 윤리적 의사결정을 측정하기 위한 목적으로 선행된 질적 서술 연구결과와 문헌고찰 및 한국 간호사 윤리선언 등을 바탕으로 하여 문항을 개발하였습니다. 이 도구의 version 1.0 은 말기환자 간호에 있어 간호사의 전문가적 책임, 도덕적 민감성, 판단력, 동기화 및 품성이 포함된 네 가지 도덕적 구성요소 및 간호사의 도덕적 행동의 세 영역, 95 문항으로 구성되었습니다.

문항의 타당도 평가를 위하여 국문으로 쓰여진 문항의 적합성, 명확성, 간결성을 평가하시고 그 결과를 아래의 연락처 sanghee.kim.1@bc.edu 나 sanghee.kim.2@gmail.com 으로 보내주시면 감사하겠습니다. 아울러 문항의 내용에 대한 귀하의 아낌없는 조언을 부탁 드립니다. 평가해 주신 측정도구를 바탕으로 성실하게 수행한 연구와 그 결과를 통해 간호학 발전에 조금이라도 도움이 되는 학자로 성장할 수 있도록 늘 노력하겠습니다. 다시 한 번 바쁘신 중에도 전문가 타당도 검증을 위해 귀한 시간을 내어 주신 것을 감사 드립니다.

연구자 김상희 올림

Sanghee Kim

Domain I: 간호사의 전문가적 책임: 27 문항 (Nurses' Professional Accountability for Good Patient Care)

간호사의 전문가적 책임은 의료전문가로서 환자에게 적절한 간호를 제공하기 위해 간호사가 마땅히 해야만 하는 임무에 대한 판단력이나 분별력을 의미한다.

간호사의 전문가적 책임 (27 문항) 1 = 전혀 동의하지 않는다 6= 전적으로 동의한다	적합성 Relevancy 1= 전혀 적절하지 않다 2= 약간 적절하다. 3= 비교적 적절하다 4= 매우 적절하다				명확성 Clarity Y=예 N=아니오		간결성 Conciseness Y=예 N=아니오	
	1	2	3	4	Y	N	Y	N
1. 간호사는 말기환자에게 최선의 간호를 제공해야 할 책임이 있다. Nurses are responsible for providing the best care for patients at the EOL.								
2. 간호사는 말기환자를 돌볼 때에 의사의 지시에 따라야 할 책임이 있다. Nurses are responsible for following the physician's orders related to care for patients at EOL.								
3. 간호사는 말기환자의 고통을 경감하도록 할 책임이 있다. Nurses are responsible for ensuring that the patient's suffering is relieved at the EOL.								
4. 말기환자를 돌봄에 있어 간호사와 의사의 판단이 상충될 때 간호사는 의사의 조언을 따라야 한다. When the nurse's judgment and the physician's conflict related to a patient's care at the EOL the nurse should follow the physician's advice.								
5. 간호사는 환자가 최선의 결정을 내릴 수 있도록 도울 책임이 있다. Nurses are responsible for assisting patients to make the best healthcare decision.								
6. 간호사는 환자 개인의 요구가 충족될 수 있도록 대변할 책임이 있다. Nurses are responsible for advocating that a patient's individual needs are met.								
7. 까다로운 환자나 불쾌감을 주는 환자를 대하게 되더라도 간호사는 차별 없이 최선의 간호를 제공해야 한다. Nurses should ensure patients receive good care even if the patient is difficult or undesirable.								

Appendix 3.

NEDM-EOLCS Version 3.0 (67 items) (English/Korean)

Nurses' Ethical Decision Making around End of Life Care Scale
(NEDM-EOLCS) Version 3.0
(English)

General Characteristics

■ Please fill in the blank or make check with V mark on the appropriate responses.

1. Age _____Years old

2. Education 1) _____ Associate 2) _____ Bachelor
3) _____ Masters 4) _____ Doctorate

3. Clinical Experience _____ Years _____ Months

4. Marital Status 1) _____ Single 2) _____ Married

5. Religion 1) _____ Catholic 2) _____ Protestant
3) _____ Buddhism 4) _____ None
5) _____ Others (Detailed_____)

6. Place of Work 1) _____ University–Affiliated Hospital
2) _____ Hospital
3) _____ Others (_____)

7. Specialty 1) _____ Cancer Center or Oncology Care Unit
2) _____ Medical Surgical Care Unit
3) _____ Intensive Care Unit or Critical Care Unit
4) _____ Gynecological Care Unit
5) _____ Hospice and Palliative Care Unit
6) _____ Others (Detailed_____)

8. Current Position 1) _____ Staff Nurse
2) _____ Nurses in Charge
3) _____ Advanced Practice Nurse
4) _____ Nurse Manager

9. What extend are you satisfied with your current work? Please check (V) the number which you thought about that.

1	2	3	4	5	6	7	8	9	10

Not satisfied at all Satisfied all

10. How often are you experienced general ethical issues in your clinical setting?

1	2	3	4	5	6	7	8	9	10

Never experienced Always experienced

Directions: The following questions are about the behavior for nurses who are taking care of patients at their end of lives. **Please rate yourself by circling the number** that most closely indicates your behavior.

1. I try to be a comforting presence for the patient who is at the EOL even when they don't need hands-on care.

1	2	3	4	5	6

Never Always

2. I encourage the patient's family to be with the patient for the final hours.

1	2	3	4	5	6

Never Always

3. I try to tailor care to a patient's individual need

1	2	3	4	5	6

Never Always

4. I try to help patients at the EOL repair problem relationships they have with important family members or friends.

1	2	3	4	5	6

Never Always

5. I ask the patient what he or she needs related to the dying process.

1	2	3	4	5	6

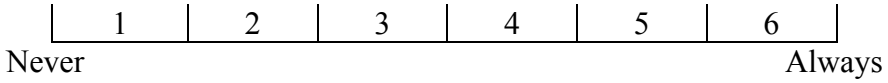
Never Always

6. I seek out available and current empirical evidence to provide appropriate End of Life (EOL) care to patients.

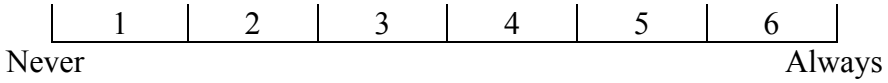
1	2	3	4	5	6

Never Always

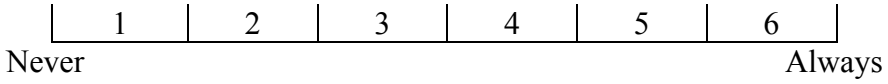
7. I try to help patients find meaning in their condition when they are facing the end of their lives.



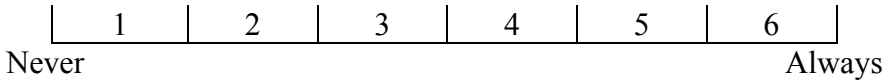
8. I use knowledge of what actions I would want for my family member to help provide care for the patient.



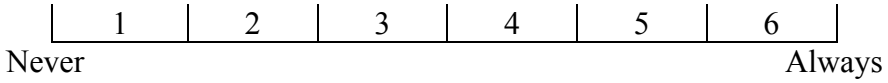
9. I try to mediate between the patient's family and other healthcare providers when there is conflict about the goals of care.



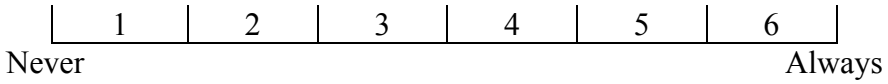
10. I try to persuade other health care professionals and the patient's family to honor the patient's wishes when they are acting contrary to what the patient wants.



11. I try to provide education to the patient and family about the purposes of any technology or therapies being used.



12. I provide appropriate information about the purposes and goals of withdrawing or withholding treatment.



13. I try to understand what the patient's preference regarding end of life care is and to advocate for these to be heard by those making the decisions.

1	2	3	4	5	6

Never Always

14. I confirm the patient's wishes or preferences regarding DNR/DNI decisions made by family members.

1	2	3	4	5	6

Never Always

15. I try to ensure that the patient's pain is relieved even if this means using high doses of opioids.

1	2	3	4	5	6

Never Always

16. I try to meet with the patient's family regularly and answer their questions.

1	2	3	4	5	6

Never Always

17. I set aside my own beliefs and values about what should occur at the EOL when caring for a patient.

1	2	3	4	5	6

Never Always

18. When patients and/or their families ask about euthanasia or assisted suicide, I try to understand their concerns.

1	2	3	4	5	6

Never Always

19. When institutional policies related to EOL practices are inappropriate, I use current evidence to try to change them.

1	2	3	4	5	6

Never Always

20. I try to ensure that the patient and his or her family are satisfied with their decisions making.

1	2	3	4	5	6

Never Always

21. I confront other healthcare providers when their actions are unethical and might cause harm.

1	2	3	4	5	6

Never Always

22. No matter what I don't completely agree with, I accept and follow the decision made by the interdisciplinary team.

1	2	3	4	5	6

Never Always

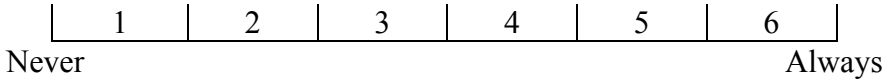
■ **Directions**: The following questions are about the components which make nurses perceive, judge, motive and act for ethical issues in clinical setting. Please **check the number** how much you agree with.

1. All nursing action for a patient should be informed by knowledge, skill, experience and an understanding of that patient's individual need.

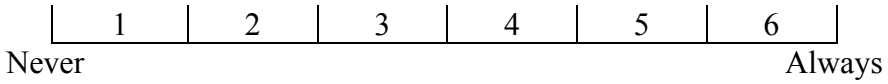
1	2	3	4	5	6

Never Always

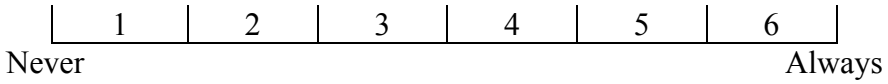
2. My actions make a difference to the patient who is facing the EOL.



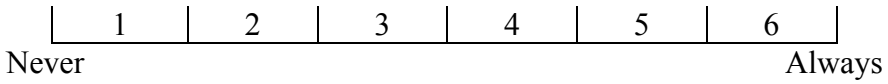
3. It is meaningful for me to ensure that I care for patient who is facing the EOL.



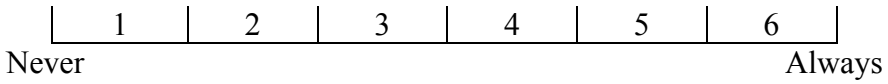
4. It is important that I am sensitive to the individual needs of patients and their family.



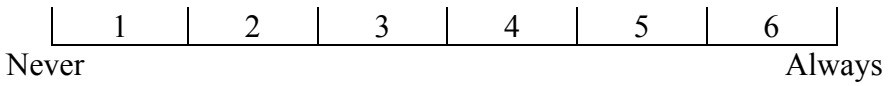
5. My personal beliefs and values can make me biased towards a particular course of action so I try to understand what these are before acting.



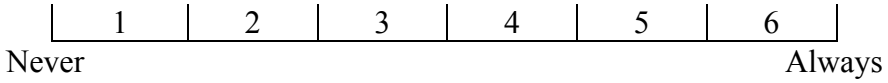
6. It is important that I remain focused on the responsibility I have toward my patient.



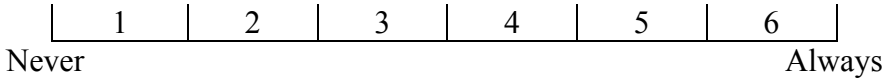
7. I recognize what are other health professionals' roles and their responsibilities.



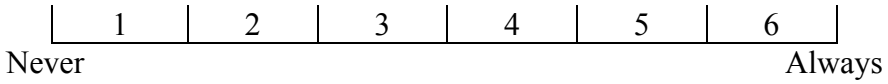
8. My patient can be harmed by nursing actions that go against his or her wishes.



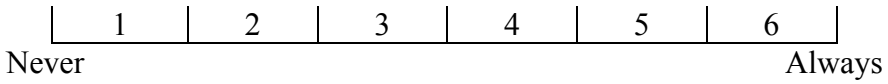
9. Routine nursing and medical procedures have ethical implications for individual patients.



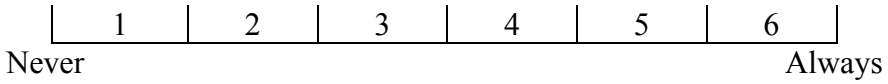
10. I am able to describe the ethical aspects of a difficult patient situation.



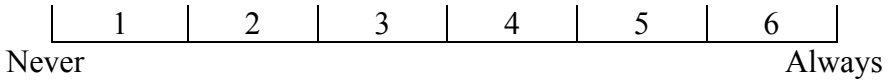
11. I can identify when an EOL decision is being made that is not in the interests of the patient.



12. I can separate out the barriers to good care in an ethical conflict.



13. I know who to go to get help in thinking through a difficult situation.



14. I feel compelled to act on behalf of my patients when I see they are not getting their needs or wishes met.

1	2	3	4	5	6

Never Always

15. When patients and or their family are thankful for my actions, it encourages me to persist in getting them what they need.

1	2	3	4	5	6

Never Always

16. When I feel a connection with the patient, I am more likely to act to meet their needs.

1	2	3	4	5	6

Never Always

17. It is too much to expect the nurse to act in the patient's behalf when she is overworked.

1	2	3	4	5	6

Never Always

18. It is my professional responsibility to get my patients needs met even when this is difficult.

1	2	3	4	5	6

Never Always

19. The support of my colleagues helps to keep me focused on getting my patient's needs met.

1	2	3	4	5	6

Never Always

20. When I am tired or upset, I am still able to focus on meeting my patient's needs in a problematic situation.

1	2	3	4	5	6

Never Always

21. My religious calling reinforces my efforts to get my patients what they need.

1	2	3	4	5	6

Never Always

22. I actively engage in ethical conflict during the end of life care and persist until the patient gets what he or she needs.

1	2	3	4	5	6

Never Always

23. I keep away from or ignore situations that cause me distress.

1	2	3	4	5	6

Never Always

24. I step back from ethical conflicts and try to think through the issues to find a solution.

1	2	3	4	5	6

Never Always

25. I feel strongly that I must try to resolve an ethical problem even if this is risky for me.

1	2	3	4	5	6

Never Always

■ Directions: The following questions are about sense of what nurses should do as healthcare professionals to provide good care for the patient. Please check the number which is extent of your agreement.

1. Nurses are responsible for providing the best care for patients at the EOL.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

2. Nurses are responsible for following the physician's orders related to care for patients at EOL.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

3. Nurses are responsible for ensuring that the patient's suffering is relieved at the EOL.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

4. When the nurses' judgment and the physician's conflict related to a patient's care at the EOL, the nurse should follow the physician's advice.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

5. Nurses are responsible for assisting patients to make the best healthcare decision.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

6. Nurses are responsible for advocating that a patient's individual needs are met.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

7. Nurses should ensure patients receive good care even if the patient is difficult or undesirable.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

8. Nurses are responsible for providing adequate information about the patient's care.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

9. It is acceptable for a nurse to withhold information from a patient when instructed to do so by a physician.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

10. Nurses are responsible for encouraging patients to be involved in the process of their care if the patient is capable.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

11. Nurses are responsible for their own practice actions.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

12. Nurses are responsible for recognizing the unethical practice of others and doing something about it.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

13. When patients refuse medical interventions, the nurse is justified in no longer providing care.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

14. The nurse should support the patient's reasoned decision to accept or refuse treatment.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

15. Nurses are responsible for ensuring that patients who have DNR (Do-Not-Resuscitate) orders still receive basic nursing care.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

16. Nurses are responsible for assisting patients to receive hospice or palliative care when invasive interventions are no longer desired or effective.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

17. Nurses are responsible for advocating that the patient gets what he or she needs even when another nurse, doctor, or family member disagree with the patients considered wishes or desires.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

18. A nurse should refuse to participate in activities which are harmful to the patient.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

19. Nurses should put the patient's safety as the first priority when she experiences a conflict with others over the patient's care.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

20. Nurses should use their clinical judgment in deciding whether a treatment or intervention is appropriate for a patient.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

Thank you for your participation in this survey.

Nurses' Ethical Decision Making around End of Life Care Scale
(NEDM-EOLCS) Version 3.0
(Korean)
말기환자를 돌보는
간호사의 윤리적 의사결정 측정도구

일반적 특성

■ 다음 사항에 대하여 서술하거나 해당 항목에 표시 (V) 하여 주십시오

1. 연령 만 _____세

2. 교육정도
   1) _____ 간호전문대학 졸업
   2) _____ 간호학과 (간호대학) 졸업
   3) _____ 대학원 석사과정 혹은 석사졸업
   4) _____ 대학원 박사과정 혹은 박사졸업

3. 임상경력 _____년 _____개월

4. 결혼상태 1) _____ 미혼 2) _____ 기혼

5. 종교상황 1) _____ 천주교 2) _____ 기독교
   3) _____ 불교 4) _____ 종교 없음
   5) _____ 기타
   (구체적으로_____)

6. 근무지 형태 1) _____ 대학병원 2) _____ 종합병원
   3) _____ 기타 의료기관 (_____)

7. 현 근무분야
   1) _____ 암센터 혹은 종양내과 병동
   2) _____ 내, 외과 일반 병동
   3) _____ 중환자실 혹은 집중 치료실
   4) _____ 부인과 병동
   5) _____ 호스피스 병동
   6) 기타

8. 현재 직위
   1) _____ 일반 간호사
   2) _____ 책임(주임) 간호사
   3) _____ 기타
   (_____)

9. 당신은 현재 하고 있는 업무에 얼마나 만족하고 계십니까? 만족 정도를 **점수로 표시 (V) 하여** 주십시오

전혀 만족하지 않는다 모두 만족한다

1	2	3	4	5	6	7	8	9	10

10. 당신은 임상현장에서 발생하는 여러 일반적인 윤리적 쟁점들에 대한 갈등을 어느 정도 자주 경험하고 계십니까? 갈등 정도를 **점수로 표시 (V) 하여** 주십시오.

전혀 갈등을 경험하지 않는다 항상 경험한다

1	2	3	4	5	6	7	8	9	10

■ I. 다음은 말기환자를 돌보는 **간호사의 행동**에 관한 질문입니다.

문항을 읽고 여러분이 평소에 행하는 정도를 **점수로 표시(V) 하여 주십시오**.

1. 나는 침상간호(직접간호) 가 필요하지 않은 말기환자라도 환자의 곁에 함께 있어주려고 한다.

1	2	3	4	5	6
전혀 이렇게 행동하지 않는다					항상 이렇게 행동한다

2. 나는 가족들이 말기환자의 임종을 지킬 수 있도록 돕는다.

1	2	3	4	5	6
전혀 이렇게 행동하지 않는다					항상 이렇게 행동한다

3. 나는 환자 개인의 필요와 요구에 따라 개별화된 간호를 제공하려 한다.

1	2	3	4	5	6
전혀 이렇게 행동하지 않는다					항상 이렇게 행동한다

4. 나는 말기환자가 가족이나 친구와의 관계에서 어려움을 겪을 때, 좋은 관계를 유지할 수 있도록 돕는다.

1	2	3	4	5	6
전혀 이렇게 행동하지 않는다					항상 이렇게 행동한다

5. 나는 환자가 죽음에 이르는 과정 동안 환자가 원하는 바가 무엇인지에 대해 물어본다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

6. 나는 환자에게 적절한 생애 말기 간호를 제공하기 위해 최신의 과학적 근거를 찾으려고 한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

7. 나는 말기에 직면한 환자가 자신의 생(生)의 의미를 찾을 수 있도록 돕는다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

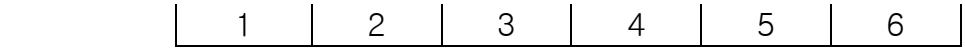
8. 나는 환자를 돌볼 때, 내 가족이라면 어떠했을 지 생각하며 행동한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

9. 환자의 치료계획이나 치료방향에 대해 가족과 의료진 사이에 갈등이 있을 때, 나는 이 갈등을 중재하려고 한다.

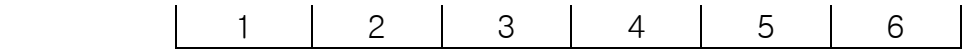
1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

10. 의료진이나 가족들이 환자가 원하는 바와 다르게 행동하려고 할 때, 나는 환자의 뜻을 존중하도록 설득하려고 한다.



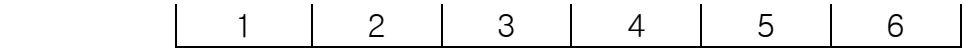
전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

11. 환자를 돌보는데 사용되는 기술이나 치료의 목적에 대해, 나는 환자나 가족에게 교육을 제공하려고 한다.



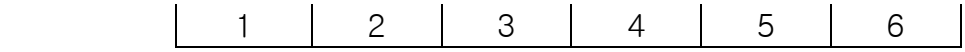
전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

12. 치료중단이나 보류의 목적에 대해, 나는 환자와 가족에게 적절한 정보를 제공한다.



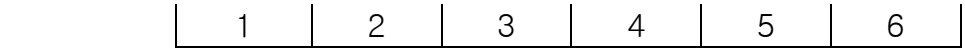
전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

13. 나는 생애 말기 치료에 대한 환자의 의사결정에 대해 다른 사람들에게 알려서 환자의 의사를 수용할 수 있도록 한다.



전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

14. 나는 가족이 내린 심폐소생술 금지와 기관 삽관 금지 (DNR/DNI) 결정에 대하여 환자의 선택과 의사가 반영되었는지 확인한다.



전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

15. 나는 고 용량의 마약성 진통제를 사용해서라도 환자의 통증을 줄이려고 한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

16. 나는 정기적으로 환자의 가족들과 면담하여 그들의 궁금증에 답을 한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

17. 나는 말기 환자를 돌볼 때 내 자신의 가치와 신념을 완전히 배제하고 환자 간호에 임한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

18. 환자와 가족들이 안락사나 의료인 조력자살에 대해 물어볼 때, 그들의 고민과 상황에 대해 이해하려고 노력한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

19. 말기환자 간호에 적절하지 않은 병원의 정책에 대해서, 나는 합리적인 근거를 제시하여 그 정책을 수정하려고 노력한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

20. 나는 환자와 가족들이 서로 만족할 만한 의사결정을 내렸는지 확인한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

21. 나는 다른 의료진의 행위가 윤리적으로 합당하지 못하여 환자에게 해를 끼칠 수 있다고 판단되면 그들과 대항한다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

22.다 학제간 팀 (interdisciplinary team) 이 결정한 환자의 치료내용과 방향이 나로서는 전혀 동의할 수 없는 결정이더라도, 나의 견해와 전혀 상관없이 수용하고 따른다.

1	2	3	4	5	6

전혀 이렇게 행동하지 않는다 — 항상 이렇게 행동한다

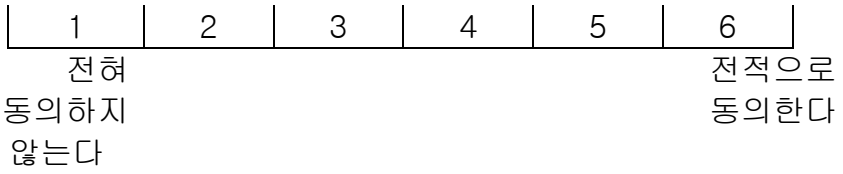
■ II. 다음은 말기환자를 돌보는 간호사가 윤리적 문제를 인식하고, 상황을 판단하고, 용기를 내어 행동에 이르게 하는 요인들에 관한 질문입니다. 문항을 읽고 여러분이 실제 동의하시는 정도의 <u>점수에 표시(V) 하여 주십시오</u>.

1. 환자에게 행하는 간호행위는 지식, 기술, 경험과 환자 개개인의 필요에 대한 전인적 이해를 바탕으로 이루어져야 한다.

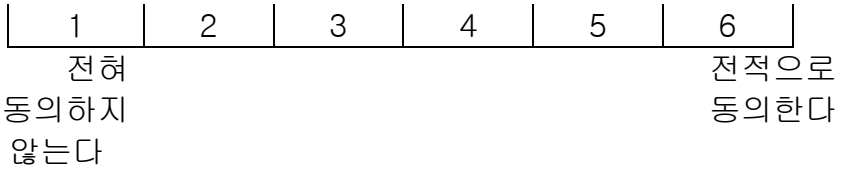
1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

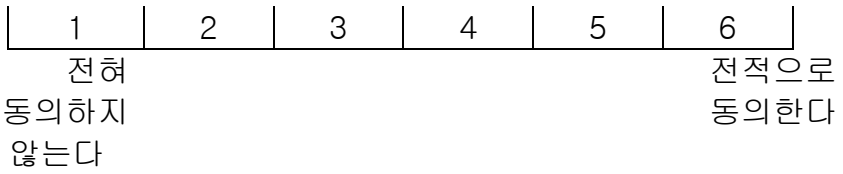
2. 내가 행하는 간호가 생애 말기에 있는 환자에게 중대한 영향을 미칠 수 있다.



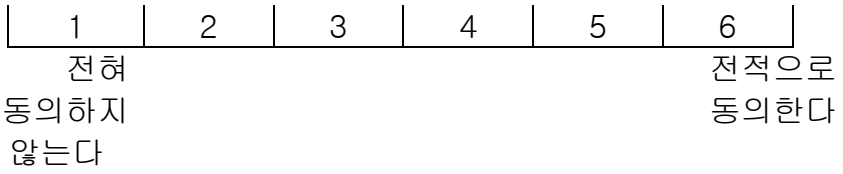
3. 생애 말기에 있는 환자를 돌보는 일은 간호사인 나에게도 의미가 있는 일이다.



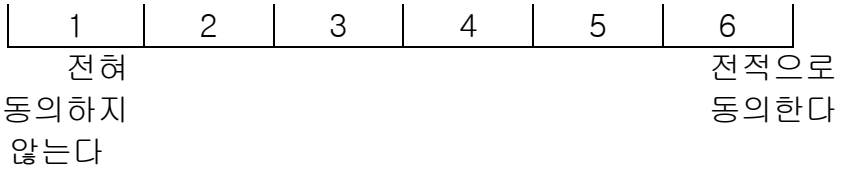
4. 내가 환자 및 가족 개개인의 요구를 민감하게 받아들인다는 사실은 중요하다.



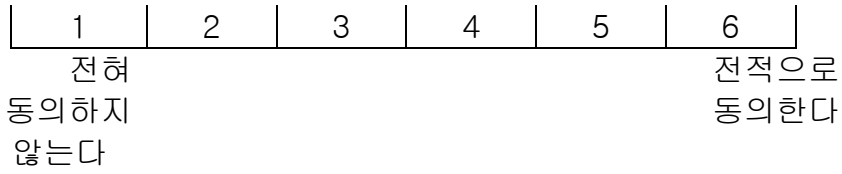
5. 나의 개인적인 신념과 가치가 간호행위에 영향을 미칠 수 있으므로, 간호실무에 임하기 전에 나의 신념과 가치에 대해 객관적으로 이해하고자 노력한다.



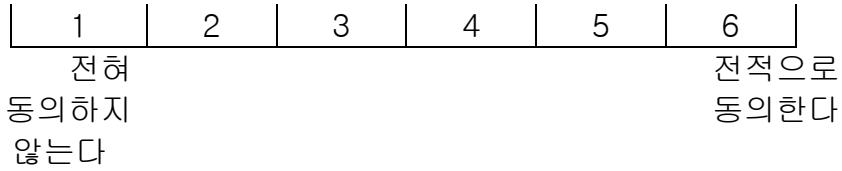
6. 내가 맡은 환자에 대해 책임을 다하여 전념하는 일은 중요하다.



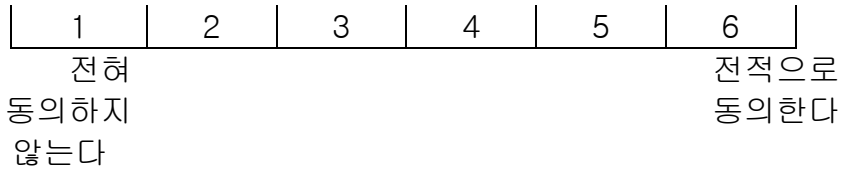
7. 나는 다른 보건의료인의 역할과 책임이 무엇인지에 대해 알고 있다.



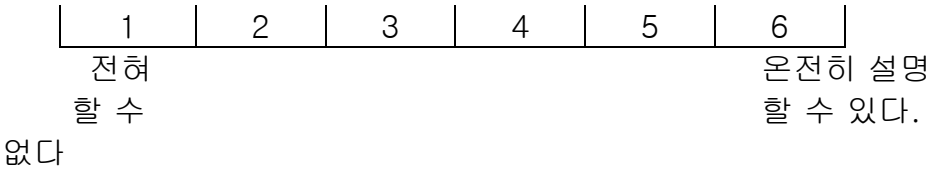
8. 나의 환자가 환자 자신의 의견과 상반되는 간호행위로 인해 위해를 당할 수도 있다.



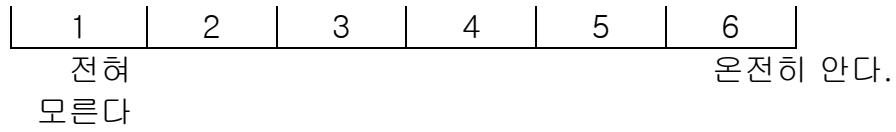
9. 개개인의 환자에게 제공되는 일상적인 간호 (routine care) 나 의료행위도 윤리적으로 중요하다.



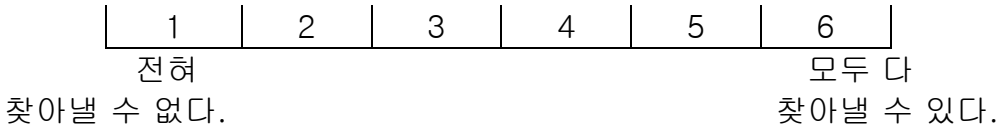
10. 나는 환자가 처한 복잡한 상황에서도 윤리적인 쟁점이 무엇인지 설명할 수 있다.



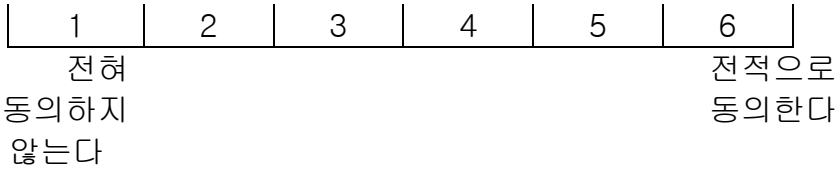
11. 나는 환자의 생애 말기에 이루어진 의사결정이 진정으로 환자를 위한 것인지 아닌지 알 수 있다.



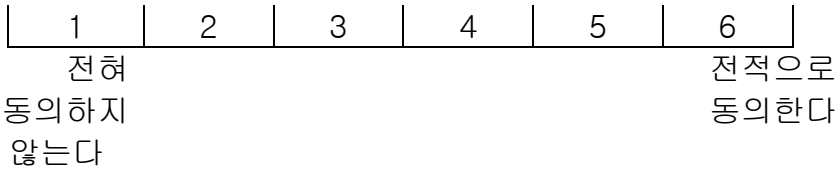
12. 나는 윤리적 갈등을 빚는 상황에서, 환자에 대한 최선의 간호를 행하는데 방해가 되는 요소가 무엇인지 찾아낼 수 있다.



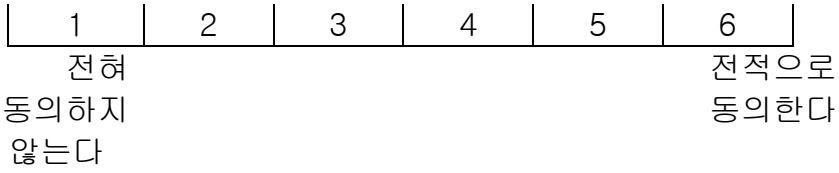
13. 상황을 판단하기 어려울 때, 나는 누구에게 도움을 청해야 할 지 알고 있다.



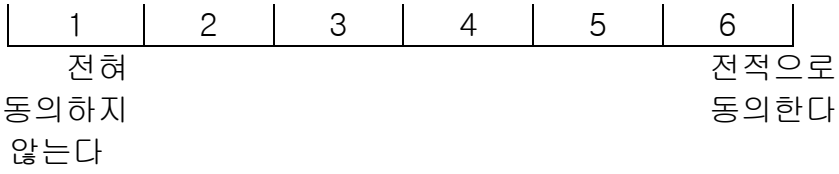
14. 나는 내 환자의 요구와 바람이 충족되지 않을 때 그들을 대신하여 나서서 행동하고 싶다.



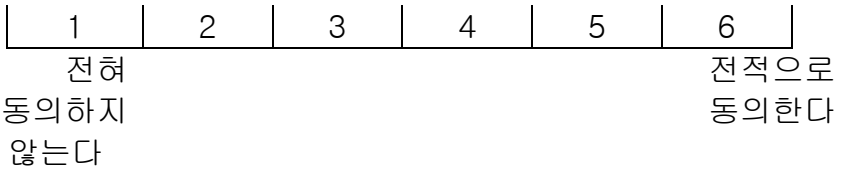
15. 환자와 가족들이 나에게 감사를 표할 때 간호를 지속하는데 큰 격려가 된다.



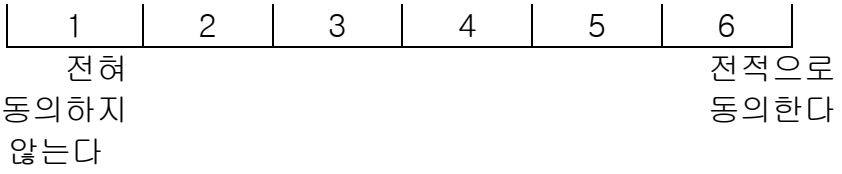
16. 환자와 친밀감을 느낄수록 환자가 원하는 바를 더 들어주고 싶다.



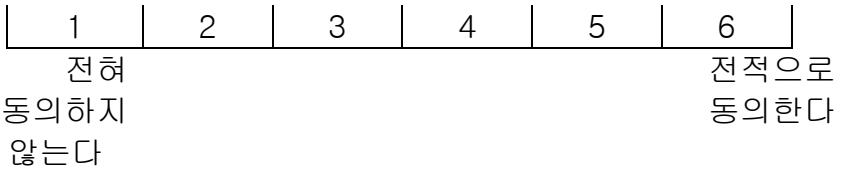
17. 업무량이 과중한 상황에서 간호사가 환자를 대신하여 행동하기를 바라는 것은 지나친 기대이다.



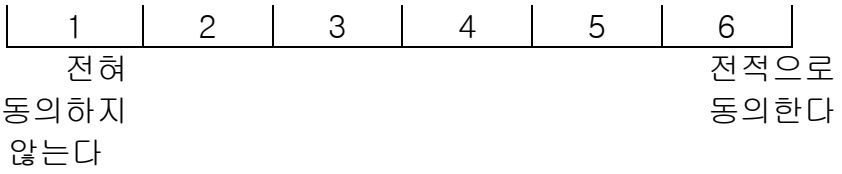
18. 여러 어려움에도 불구하고 환자를 돌보는 일은 간호사로서 나의 전문적 책임이다.



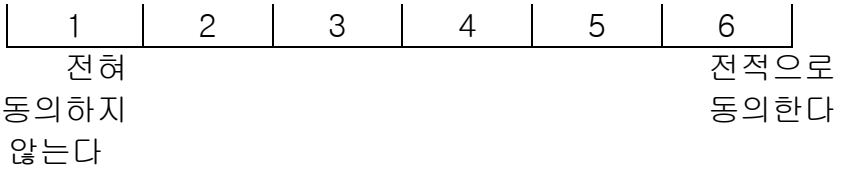
19. 동료들의 지지와 격려가 나로 하여금 간호를 지속하게 만드는데 큰 격려가 된다.



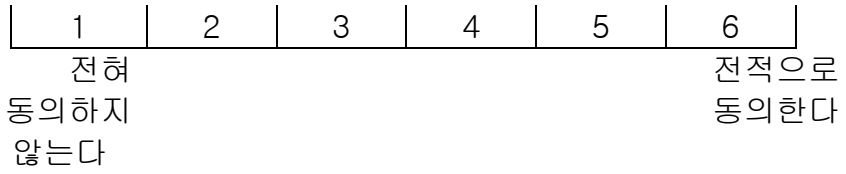
20. 내가 너무 피곤하거나 화가 나 있을 때라도 나는 여전히 환자간호에 전념할 수 있다.



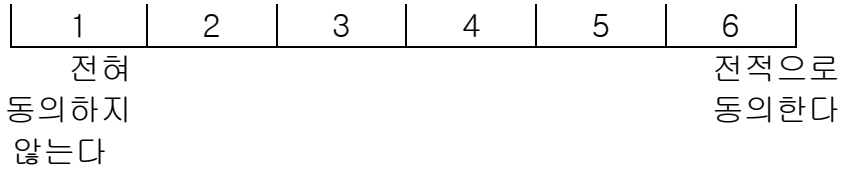
21. 종교적인 소명은 내가 열심히 환자를 돌볼 수 있도록 힘을 더해준다.



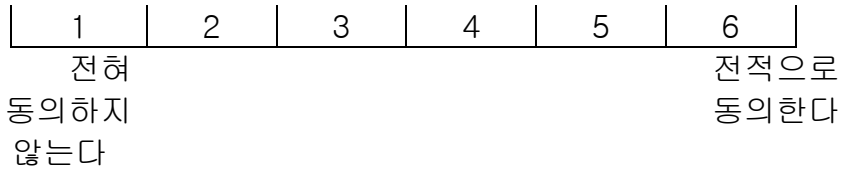
22. 나는 말기환자를 돌볼 때에 발생하는 윤리적 갈등에 대해, 환자가 만족할 때까지 적극적으로 개입한다.



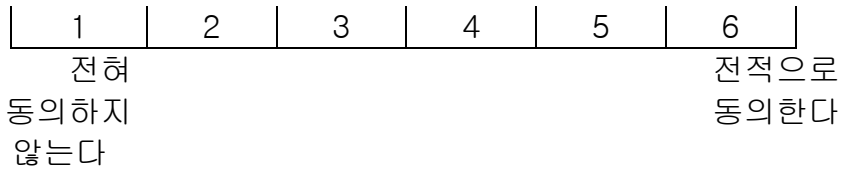
23. 나는 도덕적 고뇌를 유발하는 상황을 무시하거나 회피한다.



24. 나는 윤리적 갈등상황이 생기면, 우선 한발 물러서서 문제해결을 위하여 해결책을 찾으려고 고심한다.



25. 나에게 닥칠 위험을 감수하고라도 윤리적 문제를 해결하도록 노력해야 한다고 생각한다.



■ III. 다음은 말기환자를 돌보는 간호사의 전문가적 책임에 대한 질문입니다.

문항을 읽고 실제 여러분이 동의하시는 정도의 **점수에 표시(V) 하여 주십시오**.

1. 간호사는 말기환자에게 최선의 간호를 제공해야 할 의무가 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

2. 간호사는 말기환자를 돌볼 때 의사의 지시에 따라야 할 의무가 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

3. 간호사는 말기환자의 고통을 경감하도록 할 의무가 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

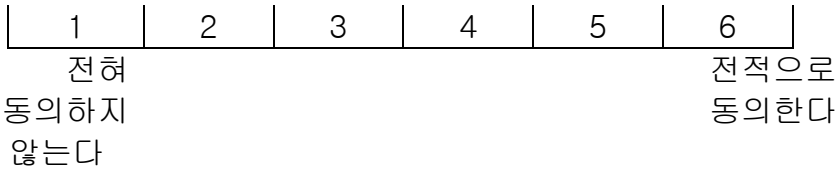
4. 말기환자를 돌봄에 있어 간호사와 의사의 판단이 상충될 때 간호사는 의사의 충고를 따라야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

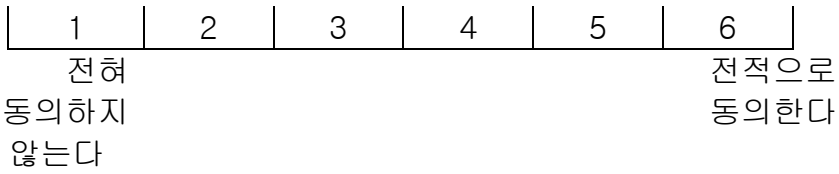
5. 간호사는 환자가 최선의 결정을 내릴 수 있도록 도와야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

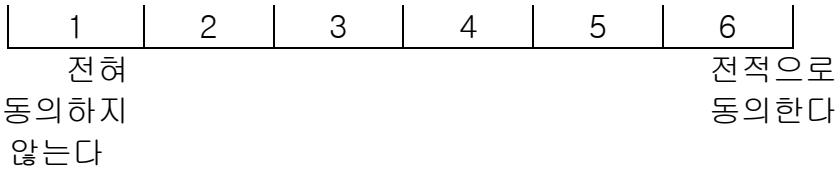
6. 간호사는 환자 개인의 요구가 충족될 수 있도록 옹호할 책임이 있다.



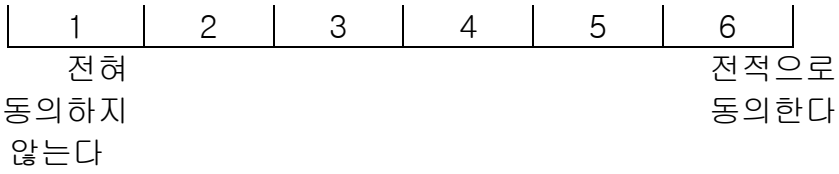
7. 까다로운 환자나 불쾌감을 주는 환자를 대하더라도 간호사는 차별 없이 최선의 간호를 제공해야 한다.



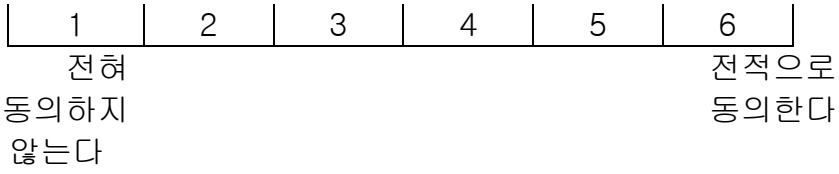
8. 간호사는 환자 간호에 있어 정확한 정보를 제공해야 한다.



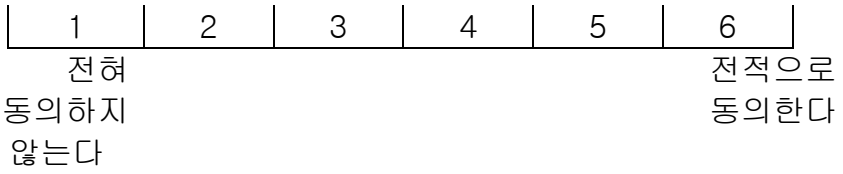
9. 의사의 지시가 있을 경우, 간호사는 환자의 정보를 일부 제한하거나 보류할 수 있다.



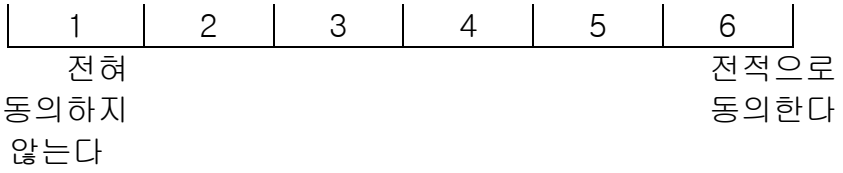
10. 간호사는 의사결정 능력이 있는 환자에게 간호의 전 과정에 참여하도록 격려할 책임이 있다.



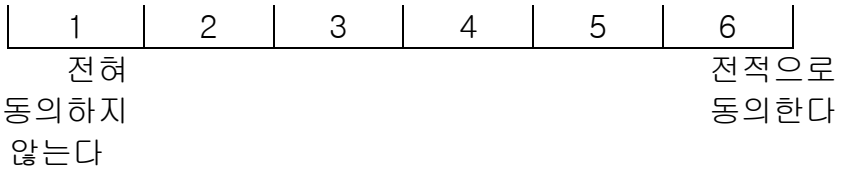
11. 간호사는 자신이 행한 간호행위에 대해 책임을 진다.



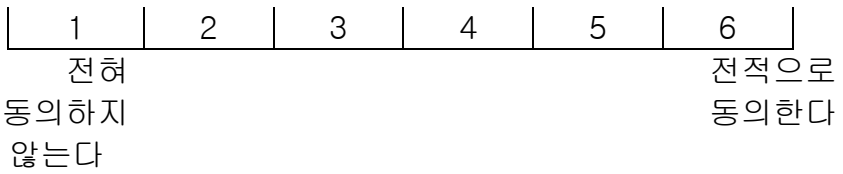
12. 간호사는 다른 사람들이 비윤리적인 행위를 하면 이를 저지할 책임이 있다.



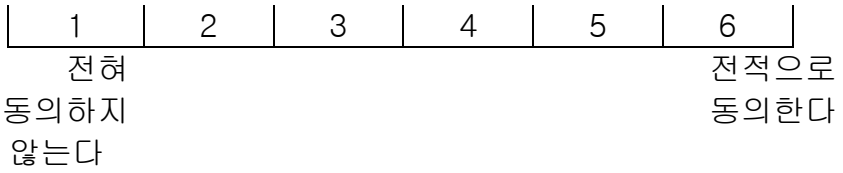
13. 환자가 치료적 중재를 거부할 경우, 간호사가 환자를 다소 소홀히 돌보게 되더라도 정당화 된다.



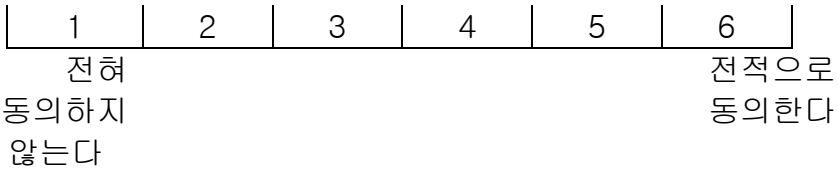
14. 간호사는 치료의 선택이나 거부에 대한 환자의 결정이 합리적이라면 이를 지지해야 한다.



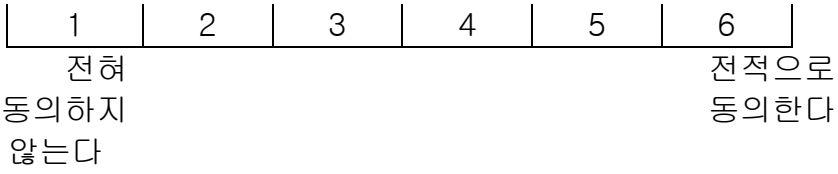
15. 간호사는 심폐소생술 금지 (DNR) 지시가 내려진 환자에게도 기본간호를 제공할 책임이 있다.



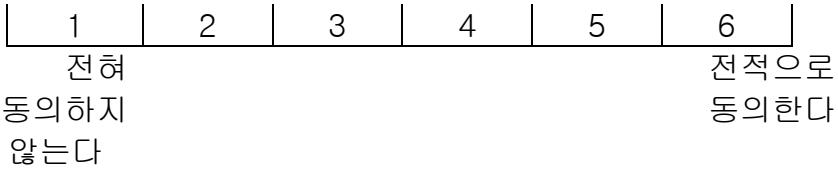
16. 간호사는 연명치료가 무의미하다고 여겨지는 말기환자를 위해 호스피스 완화간호를 제공할 책임이 있다.



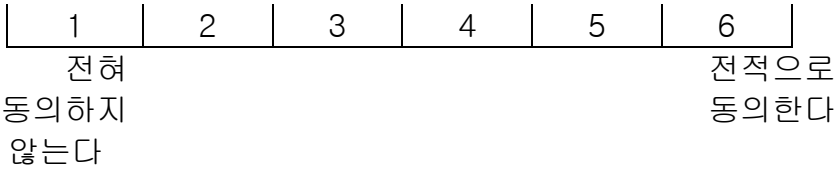
17. 다른 의료인이나 가족들이 내린 결정이 환자의 바람과 위배된다고 여겨질 때, 간호사는 환자의 뜻이 반영되도록 옹호할 책임이 있다.



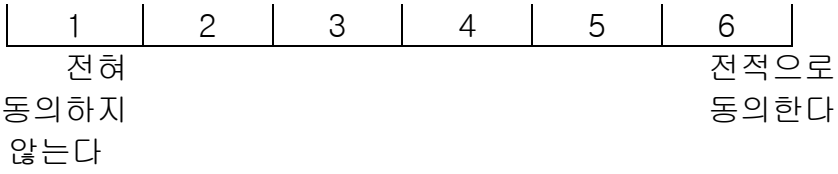
18. 간호사는 환자에게 해를 끼칠 수 있는 의료행위에 참여하는 것을 거부해야 한다.



19. 간호사는 환자를 돌보면서 다른 의료인과 갈등이 있을 때 환자의 안전을 최우선으로 여겨야 한다.



20. 간호사는 환자에게 적절한 치료나 중재가 무엇인 지 결정할 때 임상적 판단 (clinical judgment) 에 따라야 한다.



Appendix 4.

NEDM-EOLCS Version 4.0 (55 items) (Korean/English)

말기환자를 돌보는
간호사의 윤리적 의사결정 측정도구
Version 4.0

연구자: 김상희

일반적 특성

■ 다음 사항에 대하여 서술하거나 해당 항목에 표시 (V) 하여 주십시오

1. 연령 만 _____세

2. 성별 1) _____ 미혼 2) _____ 기혼

3. 교육정도 1) _____ 간호전문대학 졸업
2) _____ 간호학과 (간호대학) 졸업
3) _____ 대학원 석사과정 혹은 석사졸업
4) _____ 대학원 박사과정 혹은 박사졸업

4. 임상경력 _____년 _____개월

5. 결혼상태 1) _____ 미혼 2) _____ 기혼

6. 종교상황 1) _____ 천주교 2) _____ 기독교
3) _____ 불교 4) _____ 종교 없음
5) _____ 기타 (구체적으로_____)

7. 근무지 형태 1) _____ 대학병원 2) _____ 종합병원
3) _____ 기타 의료기관 (_____)

8. 현 근무분야 1) _____ 암센터 혹은 종양내과 병동
2) _____ 내, 외과 일반 병동
3) _____ 중환자실 혹은 집중 치료실
4) _____ 부인과 병동
5) _____ 호스피스 병동
6) 기타

9. 현재직위 1) _____ 일반 간호사 2) _____ 책임(주임) 간호사

3) _____ 기타 (_____)

10. 당신은 현재 하고 있는 업무에 얼마나 만족하고 계십니까? 만족 정도를 **점수로 표시 (V) 하여** 주십시오

전혀 만족하지 않는다 모두 만족한다

1	2	3	4	5	6	7	8	9	10

11. 당신은 임상현장에서 발생하는 여러 일반적인 윤리적 쟁점들에 대한 갈등을 어느 정도 자주 경험하고
계십니까? 갈등 정도를 **점수로 표시 (V) 하여** 주십시오.

전혀 갈등을 경험하지 않는다 항상 경험한다

1	2	3	4	5	6	7	8	9	10

■ I. 다음은 말기환자를 돌보는 **간호사의 간호실무**에 관한 질문입니다.

문항을 읽고 여러분이 평소에 행하는 정도를 **점수로 표시(V) 하여 주십시오**.

1. 나는 침상간호(직접간호) 가 필요하지 않은 말기환자라도 환자의 곁에 함께 있어주려고 한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

2. 나는 가족들이 말기환자의 임종을 지킬 수 있도록 돕는다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

3. 나는 환자 개인의 필요와 요구에 따라 개별화된 간호를 제공하려 한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

4. 나는 말기환자가 가족이나 친구와의 관계에서 어려움을 겪을 때, 좋은 관계를 유지할 수 있도록 돕는다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

5. 나는 환자가 죽음에 이르는 과정 동안 환자가 원하는 바가 무엇인지에 대해 물어본다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

6. 나는 환자에게 적절한 생애 말기 간호를 제공하기 위해 최신의 과학적 근거를 찾으려고 한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

7. 나는 말기에 직면한 환자가 자신의 생(生)의 의미를 찾을 수 있도록 돕는다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

8. 나는 환자를 돌볼 때, 내 가족이라면 어떠했을 지 생각하며 행동한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

9. 환자의 치료계획이나 치료방향에 대해 가족과 의료진 사이에 갈등이 있을 때, 나는 이 갈등을 중재하려고 한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

10. 의료진이나 가족들이 환자가 원하는 바와 다르게 행동하려고 할 때, 나는 환자의 뜻을 존중하도록 설득하려고 한다.

1	2	3	4	5	6

전혀 항상

이렇게 행동하지 않는다 이렇게 행동한다

11. 환자를 돌보는데 사용되는 기술이나 치료의 목적에 대해, 나는 환자나 가족에게 교육을 제공하려고 한다.

1	2	3	4	5	6

전혀 항상

이렇게 행동하지 않는다 이렇게 행동한다

12. 치료중단이나 보류의 목적에 대해, 나는 환자와 가족에게 적절한 정보를 제공한다.

1	2	3	4	5	6

전혀 항상

이렇게 행동하지 않는다 이렇게 행동한다

13. 나는 생애 말기 치료에 대한 환자의 의사결정에 대해 다른 사람들에게 알려서 환자의 의사를 수용할 수 있도록 한다.

1	2	3	4	5	6

전혀 항상

이렇게 행동하지 않는다 이렇게 행동한다

14. 나는 정기적으로 환자의 가족들과 면담하여 그들의 궁금증에 답을 한다.

1	2	3	4	5	6

전혀 항상

이렇게 행동하지 않는다 이렇게 행동한다

■ II. 다음은 말기환자를 돌보는 간호사가 윤리적 문제를 판단하고, 용기를 내어 행동에 이르게 하는 요인들에 관한 질문입니다. 문항을 읽고 여러분이 실제 동의하시는 정도의 점수에 표시(V) 하여 주십시오.

15. 나는 환자가 처한 복잡한 상황에서도 윤리적인 쟁점이 무엇인지 설명할 수 있다.

1	2	3	4	5	6

전혀 할 수 없다 — 온전히 설명할 수 있다.

16. 나는 환자의 생애 말기에 이루어진 의사결정이 진정으로 환자를 위한 것인지 아닌지 알 수 있다.

1	2	3	4	5	6

전혀 모른다 — 온전히 안다.

17. 나는 윤리적 갈등을 빚는 상황에서, 환자에 대한 최선의 간호를 행하는데 방해가 되는 요소가 무엇인지 찾아낼 수 있다.

1	2	3	4	5	6

전혀 찾아낼 수 없다. — 모두 다 찾아낼 수 있다.

18. 상황을 판단하기 어려울 때, 나는 누구에게 도움을 청해야 할 지 알고 있다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

19. 나는 내 환자의 요구와 바람이 충족되지 않을 때 그들을 대신하여 나서서 행동하고 싶다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

20. 내가 너무 피곤하거나 화가 나 있을 때라도 나는 여전히 환자간호에 전념할 수 있다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

21. 나는 말기환자를 돌볼 때에 발생하는 윤리적 갈등에 대해, 환자가 만족할 때까지 적극적으로 개입한다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

22. 나는 윤리적 갈등상황이 생기면, 우선 한발 물러서서 문제해결을 위하여 해결책을 찾으려고 고심한다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

23. 나에게 닥칠 위험을 감수하고라도 윤리적 문제를 해결하도록 노력해야 한다고 생각한다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

24. 나는 가족이 내린 심폐소생술 금지와 기관 삽관 금지 (DNR/DNI) 결정에 대하여 환자의 선택과 의사가 반영되었는지 확인한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

25. 말기환자 간호에 적절하지 않은 병원의 정책에 대해서, 나는 합리적인 근거를 제시하여 그 정책을 수정하려고 노력한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

26. 나는 환자와 가족들이 서로 만족할 만한 의사결정을 내렸는지 확인한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

27. 나는 다른 의료진의 행위가 윤리적으로 합당하지 못하여 환자에게 해를 끼칠 수 있다고 판단되면 그들과 대항한다.

1	2	3	4	5	6
전혀					항상
이렇게 행동하지 않는다					이렇게 행동한다

■ III. 다음은 말기환자를 돌보는 간호사의 전문가적 책임인식에 대한 질문입니다.

문항을 읽고 실제 여러분이 동의하시는 정도의 **점수에 표시(V) 하여 주십시오**.

28. 간호사는 말기환자에게 최선의 간호를 제공해야 할 의무가 있다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

29. 간호사는 말기환자의 고통을 경감하도록 할 의무가 있다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

30. 간호사는 환자가 최선의 결정을 내릴 수 있도록 도와야 한다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

31. 간호사는 환자 개인의 요구가 충족될 수 있도록 옹호할 책임이 있다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

32. 까다로운 환자나 불쾌감을 주는 환자를 대하더라도 간호사는 차별 없이 최선의 간호를 제공해야 한다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

33. 간호사는 환자 간호에 있어 정확한 정보를 제공해야 한다.

1	2	3	4	5	6

전혀 동의하지 않는다 — 전적으로 동의한다

34. 간호사는 의사결정 능력이 있는 환자에게 간호의 전 과정에 참여하도록 격려할 책임이 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

35. 간호사는 자신이 행한 간호행위에 대해 책임을 진다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

36. 간호사는 다른 사람들이 비윤리적인 행위를 하면 이를 저지할 책임이 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

37. 간호사는 치료의 선택이나 거부에 대한 환자의 결정이 합리적이라면 이를 지지해야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

38. 간호사는 심폐소생술 금지 (DNR) 지시가 내려진 환자에게도 기본간호를 제공할 책임이 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

39. 간호사는 연명치료가 무의미하다고 여겨지는 말기환자를 위해 호스피스 완화간호를 제공할 책임이 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

40. 다른 의료인이나 가족들이 내린 결정이 환자의 바람과 위배된다고 여겨질 때, 간호사는 환자의 뜻이 반영되도록 옹호할 책임이 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

41. 간호사는 환자에게 해를 끼칠 수 있는 의료행위에 참여하는 것을 거부해야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

42. 간호사는 환자를 돌보면서 다른 의료인과 갈등이 있을 때 환자의 안전을 최우선으로 여겨야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

43. 간호사는 환자에게 적절한 치료나 중재가 무엇인 지 결정할 때 임상적 판단 (clinical judgment) 에 따라야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

44. 환자에게 행하는 간호행위는 지식, 기술, 경험과 환자 개개인의 필요에 대한 전인적 이해를 바탕으로 이루어져야 한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

45. 내가 행하는 간호가 생애 말기에 있는 환자에게 중대한 영향을 미칠 수 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

46. 생애 말기에 있는 환자를 돌보는 일은 간호사인 나에게도 의미가 있는 일이다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

47. 내가 환자 및 가족 개개인의 요구를 민감하게 받아들인다는 사실은 중요하다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

48. 나의 개인적인 신념과 가치가 간호행위에 영향을 미칠 수 있으므로, 간호실무에 임하기 전에 나의 신념과 가치에 대해 객관적으로 이해하고자 노력한다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

49. 내가 맡은 환자에 대해 책임을 다하여 전념하는 일은 중요하다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

50. 나는 다른 보건의료인의 역할과 책임이 무엇인지에 대해 알고 있다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

51. 개개인의 환자에게 제공되는 일상적인 간호 (routine care) 나 의료행위도 윤리적으로 중요하다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

52. 환자와 가족들이 나에게 감사를 표할 때 간호를 지속하는데 큰 격려가 된다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

53. 환자와 친밀감을 느낄수록 환자가 원하는 바를 더 들어주고 싶다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

54. 여러 어려움에도 불구하고 환자를 돌보는 일은 간호사로서 나의 전문적 책임이다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

55. 동료들의 지지와 격려가 나로 하여금 간호를 지속하게 만드는데 큰 격려가 된다.

1	2	3	4	5	6
전혀 동의하지 않는다					전적으로 동의한다

설문에 응답해 주셔서 감사 드립니다.

Nurses' Ethical Decision Making around
End of Life Care Scale
(NEDM-EOLCS)
English Version 4.0

General Characteristics

Please fill in the blank or make check with V mark on the appropriate responses.

1. Age _____Years old

2. Gender 1) _____ Female 2) _____ Male

3. Education 1) _____ Associate 2) _____ Bachelor
3) _____ Masters 4) _____ Doctorate

4. Clinical Experience _____ Years _____ Months

5. Marital Status 1) _____ Single 2) _____ Married

6. Religion 1) _____ Catholic 2) _____ Protestant
3) _____ Buddhism 4) _____ None
5) _____ Others (Detailed_____)

7. Place of Work 1) _____ University–Affiliated Hospital
2) _____ Hospital
3) _____ Others (_____)

8. Specialty 1) _____ Cancer Center or Oncology Care Unit
2) _____ Medical Surgical Care Unit
3) _____ Intensive Care Unit or Critical Care Unit
4) _____ Gynecological Care Unit
5) _____ Hospice and Palliative Care Unit
6) _____ Others (Detailed_____)

9. Current Position 1) _____ Staff Nurse 2) _____ Nurses in Charge

3) _____ Advanced Practice Nurse 4) _____ Nurse Manager

10. What extend are you satisfied with your current work? Please check (V) the number which you thought about that.

1	2	3	4	5	6	7	8	9	10

Not satisfied at all Satisfied all

11. How often are you experienced general ethical issues in your clinical setting? P

1	2	3	4	5	6	7	8	9	10

Never experienced Always experienced

Directions: The following questions are about the practice for nurses who are taking care of patients at their end of lives. **Please rate yourself by circling the number** that most closely indicates your behavior.

1. I try to be a comforting presence for the patient who is at the EOL even when they don't need hands-on care.

1	2	3	4	5	6

Never Always

2. I encourage the patient's family to be with the patient for the final hours.

1	2	3	4	5	6

Never Always

3. I try to tailor care to a patient's individual need

1	2	3	4	5	6

Never Always

4. I try to help patients at the EOL repair problem relationships they have with important family members or friends.

1	2	3	4	5	6

Never Always

5. I ask the patient what he or she needs related to the dying process.

1	2	3	4	5	6

Never Always

6. I seek out available and current empirical evidence to provide appropriate End of Life (EOL) care to patients.

1	2	3	4	5	6

Never Always

7. I try to help patients find meaning in their condition when they are facing the end of their lives.

1	2	3	4	5	6
Never					Always

8. I use knowledge of what actions I would want for my family member to help provide care for the patient.

1	2	3	4	5	6
Never					Always

9. I try to mediate between the patient's family and other healthcare providers when there is conflict about the goals of care.

1	2	3	4	5	6
Never					Always

10. I try to persuade other health care professionals and the patient's family to honor the patient's wishes when they are acting contrary to what the patient wants.

1	2	3	4	5	6
Never					Always

11. I try to provide education to the patient and family about the purposes of any technology or therapies being used.

1	2	3	4	5	6
Never					Always

12. I provide appropriate information about the purposes and goals of withdrawing or withholding treatment.

1	2	3	4	5	6
Never					Always

13. I try to understand what the patient's preference regarding end of life care is and to advocate for these to be heard by those making the decisions.

1	2	3	4	5	6

Never Always

14. I try to meet with the patient's family regularly and answer their questions.

1	2	3	4	5	6

Never Always

■ **Directions**: The following questions are about the components which make nurses judge and act for ethical issues in clinical setting. Please **check the number** how much you agree with.

15. I am able to describe the ethical aspects of a difficult patient situation.

1	2	3	4	5	6

Never Always

16. I can identify when an EOL decision is being made that is not in the interests of the patient.

1	2	3	4	5	6

Never Always

17. I can separate out the barriers to good care in an ethical conflict.

1	2	3	4	5	6

Never Always

18. I know who to go to get help in thinking through a difficult situation.

1	2	3	4	5	6

Never Always

19. I feel compelled to act on behalf of my patients when I see they are not getting their needs or wishes met.

1	2	3	4	5	6

Never Always

20. When I am tired or upset, I am still able to focus on meeting my patient's needs in a problematic situation.

1	2	3	4	5	6

Never Always

21. I actively engage in ethical conflict during the end of life care and persist until the patient gets what he or she needs.

1	2	3	4	5	6

Never Always

22. I step back from ethical conflicts and try to think through the issues to find a solution.

1	2	3	4	5	6

Never Always

23. I feel strongly that I must try to resolve an ethical problem even if this is risky for me.

1	2	3	4	5	6

Never Always

24. I confirm the patient's wishes or preferences regarding DNR/DNI decisions made by family members.

1	2	3	4	5	6

Never Always

25. When institutional policies related to EOL practices are inappropriate, I use current evidence to try to change them.

1	2	3	4	5	6

Never Always

26. I try to ensure that the patient and his or her family are satisfied with their decisions making.

1	2	3	4	5	6

Never Always

27. I confront other healthcare providers when their actions are unethical and might cause harm.

1	2	3	4	5	6

Never Always

■ Directions: The following questions are about sense of what nurses should do as healthcare professionals to provide good care for the patient. Please check the number which is extent of your agreement.

28. Nurses are responsible for providing the best care for patients at the EOL.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

29. Nurses are responsible for ensuring that the patient's suffering is relieved at the EOL.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

30. Nurses are responsible for assisting patients to make the best healthcare decision.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

31. Nurses are responsible for advocating that a patient's individual needs are met.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

32. Nurses should ensure patients receive good care even if the patient is difficult or undesirable.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

33. Nurses are responsible for providing adequate information about the patient's care.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

34. Nurses are responsible for encouraging patients to be involved in the process of their care if the patient is capable.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

35. Nurses are responsible for their own practice actions.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

36. Nurses are responsible for recognizing the unethical practice of others and doing something about it.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

37. The nurse should support the patient's reasoned decision to accept or refuse treatment.

1	2	3	4	5	6

Strongly Disagree Strongly Agree

38. Nurses are responsible for ensuring that patients who have DNR (Do-Not-Resuscitate) orders still receive basic nursing care.

1	2	3	4	5	6

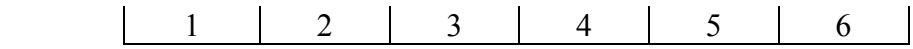
Strongly Disagree Strongly Agree

39. Nurses are responsible for assisting patients to receive hospice or palliative care when invasive interventions are no longer desired or effective.

1	2	3	4	5	6

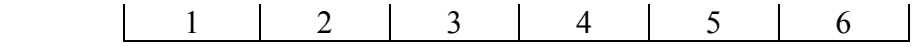
Strongly Disagree Strongly Agree

40. Nurses are responsible for advocating that the patient gets what he or she needs even when another nurse, doctor, or family member disagree with the patients considered wishes or desires.



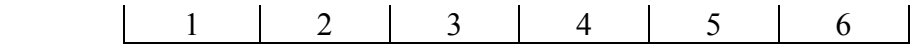
Strongly Disagree Strongly Agree

41. A nurse should refuse to participate in activities which are harmful to the patient.



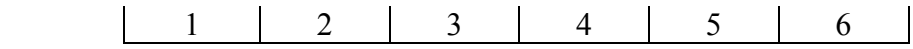
Strongly Disagree Strongly Agree

42. Nurses should put the patient's safety as the first priority when she experiences a conflict with others over the patient's care.



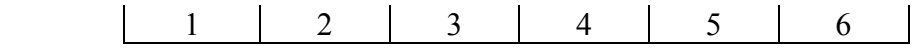
Strongly Disagree Strongly Agree

43. Nurses should use their clinical judgment in deciding whether a treatment or intervention is appropriate for a patient.



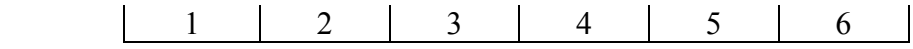
Strongly Disagree Strongly Agree

44. All nursing action for a patient should be informed by knowledge, skill, experience and an understanding of that patient's individual need.



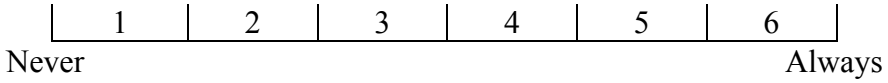
Never Always

45. My actions make a difference to the patient who is facing the EOL.

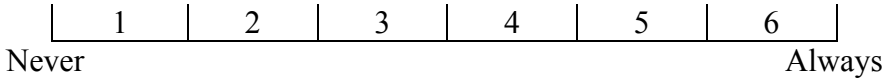


Never Always

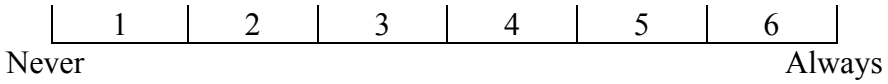
46. It is meaningful for me to ensure that I care for patient who is facing the EOL.



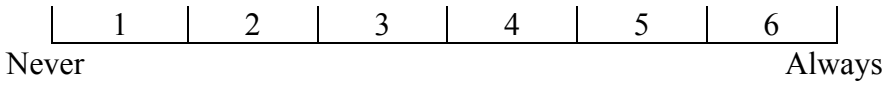
47. It is important that I am sensitive to the individual needs of patients and their family.



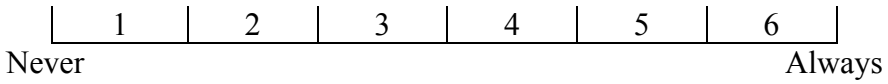
48. My personal beliefs and values can make me biased towards a particular course of action so I try to understand what these are before acting.



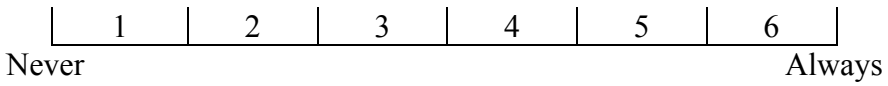
49. It is important that I remain focused on the responsibility I have toward my patient.



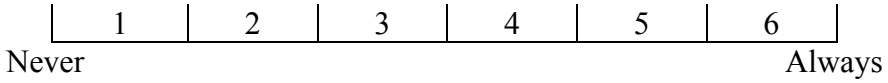
50. I recognize what are other health professionals' roles and their responsibilities.



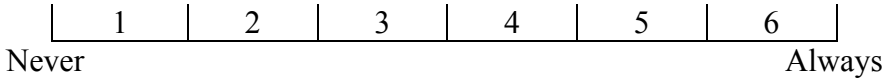
51. Routine nursing and medical procedures have ethical implications for individual patients.



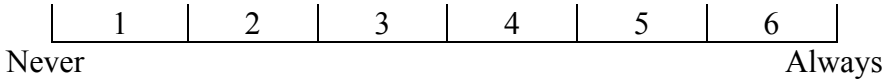
52. When patients and or their family are thankful for my actions, it encourages me to persist in getting them what they need.



53. When I feel a connection with the patient, I am more likely to act to meet their needs.



54. It is my professional responsibility to get my patients needs met even when this is difficult.



55. The support of my colleagues helps to keep me focused on getting my patient's needs met.