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ROLE CONCEPTION, ETHICAL DECISION-MAKING AND LEARNING CLIMATE AMONG NURSING STUDENTS IN HONG KONG

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By

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ABSTRACT

Previous studies showed that ethical decision-making was related to role conception types and the work environment. The socialization process of education also has a tremendous impact on the ethical behaviour and the role conception of nursing students. The present study examined the relationship among the ethical decision-making, nursing role conception and perception of learning climate of the student nurses from the hospital-based certificate and degree educational programmes in Hong Kong. Nonprobability convenience sampling was used. The subjects were 140 certificate and 81 degree nursing students. The former were in their first, third and fourth study block of study whereas the later were in their second, third and fourth year. The role conception scale developed by Pieta (1976) was modified and adopted to study the respondent's perception of the what the role should be and what actually is in practice. The three role conception scale--professional, bureaucratic, and service were all adopted for this study. For the ethical decision-making, the Judgment About Nursing Decisions (JAND) scale developed by Ketefian (1981) was used. To examine students' perception of the ward learning climate, Orton's (1981) Ward Learning Climate was modified and used in this study.

The results showed that the degree had a significantly higher ideal but lower actual professional role conception than the certificate students. Interaction effect between the groups (certificate-degree) and grades (stages of education) was detected in the ideal professional role indicating a marked drop of the score for the fourth year degree students. Actual ethical decision-making score was also

significantly lower in the degree students. For the discrepancy role conception score, the degree students had a significantly higher discrepancy score in all the three role conception types when compared with their certificate counterparts. No significant difference was detected in the perception of learning climate between the two groups. However, multiple regression analyses showed the ideal professional role conception was a significant predictor, accounting for 17% of the variance in the ideal ethical score. Actual service role conception was a better predictor of the actual ethical score, explaining 10% and 14% of its variance for the certificate and degree students respectively. Learning climate variables was found to account for an additional 9% of the variance in the actual ethical score for the degree students only. Professional role discrepancy was found to relate to ethical score negatively. In summary, the impact of ward learning environment on the development of nursing role conception and students' ethical decision-making ability was demonstrated. Compared to the certificate students, the ward practice seem to exert far greater impact on degree students' role conception and dilemma resolution ability.

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CHAPTER 1

INTRODUCTION

Background of the Study

The hospital-based nursing training programme has long been criticized as providing a very narrow scope of learning. In addition there has been a considerable concern that the programme is inadequate in preparing nurses for the expanded responsibilities and extended roles imposed on them. Although there have been significant changes in the health care system and nature of health needs in the past two decades, the current content of the curriculum in Hong Kong hospital nursing schools is basically the same as the one developed over 20 years ago. The curriculum has a strong emphasis on the teaching of nursing procedures and medical knowledge of diseases. Students are taught to repeat and imitate what others have done rather than develop original thinking. The replication of steps in nursing procedures rather than the understanding and application of the principles behind each step is an example. Any questioning of the procedure will be considered as a challenge to the knowledge of the authority (Wong & Wong, 1988). As a result, students are moulded into a fixed pattern of thinking and become "uncritical replicators of traditional nursing practice" (French, 1989, p.19).

Thus, when students are constantly confronted with ethical dilemmas in the clinical situations which require certain degree of flexibility and independent judgment, they find themselves handicapped in making ethical decisions. In fact, taking an ethical stance on behalf of the patient's best interest might demand

nurses to challenge or even stand against the decision of the employing authority or their seniors.

It has been indicated that nursing students tended to adopt a bureaucratic-centred rather than a patient-centred approach as the best initial way in resolving ethical dilemmas (Swider, McElmurry & Yarling, 1985). Being part of the work force, nursing students are expected to work without supervision in much of the time. Therefore, in order to survive in clinical practice without incurring detrimental consequences, they learn to work through the bureaucracy by avoiding mistakes and merely doing what "they are told to do". In this learning process, they are socialized to subordinate to hospital goals and decisions of ward sisters who have been suggested to be the most influential person in determining the ward learning (Fretwell, 1982; Ogier, 1982). Very often, patients' needs are given only low priority by the students (French, 1989).

Compounding this is the problem of the theory and practice gap. It is evident that the content taught in school is not practised on the wards and students have been increasingly frustrated by different standards in nursing care between the school and the wards. While the students are in nursing school, they are socialised to a role that values holistic care and a caring approach to patients' needs. But once they enter into clinical practice, they find that many of these role values are not functional. Students who enter the training with an ideal for humanitarian service will soon find themselves struggling with choices between serving the patient's needs or getting on with the routine work proficiently; performing nursing tasks according to the ward practice or to instructions from their school tutors. This discrepancy has made students to learn theories in school

to pass examinations. Studies have shown the relationship between role conflict and wastage among nurses (Kramer, 1974; Taunton & Otteman, 1986). An individual who is engaged in constant role conflict would either resolve it by readjusting to the role expectation or by leaving the profession. There has been considerable concern about the increasing drop-out rate of nursing students as well as turnover rates of nurses in the recent years in Hong Kong (Veloo,1993; Wan, 1994; Weldon, 1994). As a nurse educator, the author is very much bewildered by this phenomenon. According to Ketefian (1985), degree nurses scored higher on professional role conception which was positively related to ethical decision-making as compared to diploma nurses. Yet, nurses who were professionally oriented were found to leave nursing sooner than those who were bureaucratically oriented because of the role conflict experienced in the practice setting. Such role conflict also had a negative effect on ethical decision-making. It is apparent that the hospital ward which serves its dual functions as both a "learning" and "work" arena has a great impact on the development of role conception and ethical decision-making of both students and graduate nurses.

Given the above phenomena, the author is highly interested to find out firstly, the profile of ethical decision-making in relation to the role conception types and secondly, the perception of ward learning climate of the nursing students from the hospital-based and degree educational nursing programmes.

Significance of the Study

The research related to impacts of the role conception, educational preparation and working environment on ethical decision-making have been applied to degree and diploma nursing students and hospital staff in North America. In Hong Kong , unlike American nursing students, the majority of nurses are trained under an apprenticeship system and most of the training take place in the hospital practice setting. Therefore, it is argued that the educational preparation which cultivates the formation of the role conception and the ward learning environment will have a far greater impact on the ethical decision making of student nurses in Hong Kong than in those of the America. As nursing degree programmes have only been in existence in Hong Kong since 1990, it may be appropriate to find out if the Chinese nursing students with degree preparation have any differences in their ethical decision-making to those students prepared in the hospital-based training. In addition, it would be useful to discover if nurses in Hong Kong differed from their American counterparts.

To the knowledge of the author, there is no study being done on the relationship between the ward learning climate and ethical decision making. The result of this study could provide some insights on how nursing students respond in dilemma situations and how factors in the ward environment and educational programmes relate to role conception types. It is anticipated that such information would be useful for nurse educators and administrators with the responsibility of preparing nursing students for ethical dilemma. This could in turn assist in the appropriating a ward learning environment conducive to ethical decision making in connection with role conception types.

Purpose of the Study

The purpose of this study was to investigate the impact of nursing education on the role conceptions and dilemma resolution of student nurses in Hong Kong. The influence of the ward learning climate was also considered. The study attempted to answer the questions as follows:

1. How is the role conceptions of the hospital-based certificate nursing students different from the baccalaureate degree nursing students?
2. How is the ethical behaviour of the hospital-based certificate nursing students different from the baccalaureate degree nursing students?
3. How is the role discrepancy of the hospital-based certificate nursing students different from the baccalaureate degree nursing student?
4. How is the perception of the ward learning climate of the hospital-based certificate nursing students different from the baccalaureate degree nursing students?
5. What are the relationships among ethical decision-making, role conception and perception of learning climate of the nursing students from the two nursing education programmes?

CHAPTER 2

REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK

Role Conception

Role. A review of literature on role theory showed diverse definition of role between different disciplines such as psychology and sociology (Gross, Mason & MacEachern, 1958). The differences usually revolve around describing the expected behaviour in a particular position or the actual behaviour in a given position (Pieta, 1976).

Biddle (1979) defined role as a set of behaviours expected of an individual in a given position. Similar to this definition, Getzel and Guba (1954) referred to role as a set of expectation regarding an individual in his interaction with others. Corwin (1960) and Eisenstadt, Weintraub and Toren (1967) defined role as a pattern of behaviour which is socially accepted on an individual or within a group in a specified situation.

Some defined role as an individual's perception of his situation in relation to his and other's social position (Mead, 1949; Pieta, 1976). It is linked with a particular position and the person occupying that position. According to Mead, the relevant others in a similar situation have a great deal of impact upon the shaping of values and attitudes and thus the behaviour of an individual. Through interaction, such prescribed values, attitudes and behaviour are gradually internalized by an individual and become congruent with those relevant others.

In summary, roles can be defined in a variety of ways, however, expected behaviour, social position in context are common elements identified. Role could

then be referred to as certain expected behaviours of an individual in a given social position.

Role Conception. Role conception is the expectations held for one's own behaviour and the behaviour of others in a given situation. (Taunton, 1986). It is acquired through personal experience, listening to or observing what should and should not be done in a particular circumstances.

Taves, Corwin and Hass (1963) discussed role conception in relation to occupation. There are norms and value within an occupation and people working within it are expected to adopt them. The identification of these expectation is referred as individual's "role conception".

The role conception is acquired through socialization (Pieta, 1976). Through the learning of norms and values expected of them, individuals become socialized into a particular role. While students are in their training, they are undergoing a process of indoctrination of norms and value important in a given situation.

Abrahamson (1967) and Clausen et al. (1968) categorized the socialization process into two types, "professional" and "organizational". "Professional socialization" occurs when an individual receives his/her education in a professional school. In the process an individual is socialized to commit to the value of a profession which is characterized by specialized competence and extensive autonomy in exercising it. Strong commitment to a career based on its specialised skill and its own standards to govern decision-making is also emphasized.

The second type is called "organizational socialization" which is the result of learning and adjustment to the norms and regulations of the organization employing the new professional graduate. In order to seek recognition from superiors and advancement within a hierarchial structure, an individual's commitment to their professional values and specialized skill may be changed to being more organizational committed. In the process of organizational socialization, an individual is moulded to become more committed to the organization's roles and tasks; to implement specific goals in rational and efficient ways and orient to impersonal contacts between official and clients (Kramer, 1971). Kornhauser's (1962) study of scientists in an organization indicated that those scientists who were high in their professional orientation upon graduation became more bureaucratically oriented following employment. They were also more successful in making advancement to administrative post.

Nursing Role Conception. Corwin (1960) described three types of nursing role conceptions, "professional", "bureaucratic" and "service". The "professional role conception" requires commitment to the occupational principles, technical and medical standards of performance, formal knowledge and to active involvement in the professional association. It is associated with a set code of professional ethics which transcends the location of a particular hospital. The "bureaucratic role conception" demands primary loyalty to the hospital policies, work routines and personnel supervision. Employees working within the hospital are committed to taking orders from seniors and emphasize performance in accordance with rules and regulations established by the organization's hierarchy.

The "service role conception" refers to a primary loyalty to the patient and emphasizes humanitarian services to patients. It is based on the idea that personal satisfaction is derived from engaging in humanitarian duties. According to Corwin, the "service role conception" is probably the most enduring of the three.

All these three conceptions could be held simultaneously and inconsistently by an individual in varying degree. The greater the perceived inconsistency among the roles, the greater the frustration experienced. Besides, when there is perceived differences between the way the role is practised and should be practised, role discrepancy occurs (Corwin, 1961a).

Role Discrepancy. Corwin (1961a) used the terms role discrepancy to measure the extent of role conflict occurring within an individual. It refers to the extent to which an ideal role conception is perceived as unrealistic and nonfunctional in work situation. The degree of discrepancy is dependent upon the individual's perception of the suitability of the situation in carrying out his/her role. The more limitations imposed on an individual to enact the role as conceived, the more frustrations experienced (Pieta, 1976).

Shead (1991) asserted that professional-bureaucratic work conflict remains the most widely discussed cause of role conflict within the nursing profession. As argued by Melia (1981, 1987), the education segment is concerned with producing a nurse capable of making independent judgment and professional practice, whilst the service sector is concerned with promoting a compliant and efficient attitude in students. Another cause of role conflict is that arising from difference between the nurse's own personal values and those of the profession

(Shead, 1991).

The findings of Taunton (1986) indicated that bureaucratic and professional role conflict continued to be the potential sources of stress for staff nurses. Kramer and Rigiolizzo-Gurenlian (1985) believed that the bureaucratic-professional conflict was a major factor for nurses to leave nursing.

Change of Role Conception. Based on Corwin's scale, Kramer (1966) examined the role conception of nursing students and graduates in transition from school to the working world. She found that the bureaucratic role conception sharply increased upon entry to the bureaucratic setting while the professional and service role conception showed a gradual decline. The sharp change could be accounted for the desperate need to adjust to a new environment which was highly bureaucratically oriented. It was also found that the strength of bureaucratic role conception increased with the length of employment. Higher role discrepancy occurred in those who maintained a high professional role.

Another study by Kramer (1970) demonstrated that there was a higher bureaucratic role conception in those nurses who were promoted to a higher position and that there were lower scores for role discrepancies among these "successful" nurses. A longitudinal study by Kramer and Baker (1971) indicated that nurses who maintained a high professional role conception tended to leave nursing. Aiming to assist students in making transition from students to graduate with minimal frustration and conflict, Kramer (1974) conducted an experimental Anticipatory Socialization programme on baccalaureate nursing students. The results of this study over an eight-year period showed that classes who had the

Anticipatory programme scored higher in bureaucratic role conception than the control classes. The graduates also stayed in nursing practice longer and experienced lower score in role discrepancy.

Socialization and Role Conception

The term 'socialization' has a history of varied use, but it has come to be viewed more as an interactional process in which the individual joining the group and the socializer are mutually influenced (Hurley-Wilson, 1988). Brim (1966) referred socialization from a role perspective. It is a process by which individuals acquire skill, knowledge and dispositions accepted by a group through a process of learning within an interactional context. In the process, the role behaviour attached to the various positions and statuses within the social structure is learned.

Education is a process of socialization. Students enroled in nursing programme undergo a socialization process similar to other students preparing for professional practice in other discipline. Through identification with norms and value or a particular role model, internalization occurs and the role model's values becomes part of the student's values.

Abrahamson (1967) and Williams and Williams (1959) described three types of identification which led to establishment of the professional ideals. The first type is identification with legendary figures such as Florence Nightingale whose life images a self-sacrificing and untiring ideal norms. The second type is identification with an ongoing system which emphasizes rational and scientific approach of caring to the sick. The third type of identification is the influence resulting from the interaction of students and faculty which has been reported as

the most influential process in the development of role conception among baccalaureate students. The closer students' attitudes and values match their faculty, the more likely they have adopted the professional view of nursing (Cohen & Jordet, 1988; Whelan, 1984). Just, Adams and DeYoung (1989) and Kramer, Polifroni and Organek (1986) also agreed that students who were taught by faculty who were actively involved in practice had better integration of theory into practice, realistic perception of work environment, more interests in nursing research and more independent thinking.

Socialization of Baccalaureate Degree Students. It was indicated that baccalaureate students had a higher professional and service role conception than associate degree students (Davis, 1972). During the educational process, the bureaucratic role conception decreased and commitment to professional value increased from entrance to graduation. Moreover, most of the change in professional loyalty took place early in the programme (Davis & Olesen, 1964; Kramer, 1968).

A study of role conception by Hover (1975) on baccalaureate and diploma students indicated that degree nurses scored higher in "professionalism" and "perceived ability to communicate autonomous aspects of leadership" (Hover, 1975 p.68). They were also more interested in patient teaching and supportive care than the diploma nurses who were more interested in technically oriented tasks. Murray and Morris (1982) showed that the baccalaureate students scored significantly higher degree of creativity and spontaneity in terms of professional autonomy when compared with the associate and hospital-based students. It was

also indicated that baccalaureate degree prepared nurse had significantly higher mean scores in critical thinking ability than the associate and diploma nurse (Frederickson & Mayer, 1977; Pardue, 1987). A more recent research study by Langston (1990) further supported the assertion that the baccalaureate students was socialised to function in an autonomous and independent role, while the associate degree student was socialised to provide traditional pattern of nursing care.

Socialization of Hospital-based Certificate Students. The apprenticeship type of nursing training has been criticized as mechanistic and pedagogical in nature. Transmission of knowledge with information overload and in forms of didactic teaching is emphasized in nursing school (French, 1989). Under this kind of learning students are socialized into passive-dependent learners and eventually passive-dependent practitioners (Burnard, 1985; Stephenson, 1984).

Being an employer, yet a learner at the same time, students are left to work independently without supervision in much of the time and there are certain implicit role behaviours expected from them. They are expected to "do as you are told"; "keep busy and on the go"; "never make a mistake". In fact, working according to rules and regulation or according to the norms is conceived as the most efficient and safest ways of completing a task. According to Mauksch (1972 cited in Wolinsky, 1980), students in the apprenticeship nursing training were socialized to be subordinate to hospital goals and needs; subordinate to doctors and be capable to cope at all time.

Nursing and Ethics

The increasing dependence on the advanced technology for diagnostic and treatment modalities and the cost-effective approach to allocation of health care in the past two decades have aroused heightened awareness of ethical issues in nursing practice. This awareness is reflected in growing numbers of ethics committees, governmental and professional policies and regulations intended to deal with the increasing complexity of ethical dilemmas (Cassidy, 1991).

Besides, the changing roles of the nursing profession also increases the nurses' involvement in decision-making about ethical issues. An examination of nursing literature indicated that nurses have been becoming increasingly aware of their ethical responsibilities in providing care (Davis, 1981; Murphy, 1984). However, one has to recognize an ethical dimension of practice before one can act ethically. It has been indicated that nurses have difficulty in identifying ethical dilemma and choosing an appropriate course of action (Holly, 1986; Zablow, 1984/1985). Holly indicated that only 54% of nurses in his study were able to identify nursing dilemma. Zablow found that nurses had difficulty in recognizing moral elements inherent in a situation and making ethical choices.

Aroskar (1982) cited as an example a nursing home administrator who claimed that she had no ethical dilemma although there were comatose patients who were on respirators and being transported for dialysis. It has been asserted that owing to lack of knowledge about ethical concepts and ethical decision-making process, nurses are often ill prepared to address ethical dilemma and let alone participate in ethical decision making (Aroskar, 1982; Fry, 1985). As a consequence, a framework based on ethical principles and decision-making

process is needed in order to structure and clarify a dilemma before resolving it.

Ethical Dilemma. Davis & Aroskar (1991) defined a dilemma as " a difficult problem seemingly incapable of a satisfactory solution; or a situation involving choice between equally unsatisfactory alternatives" (p.7). It involves a choice between two equally difficult or bad alternatives. There is no definite nor clear-cut answer but a certain degree of uncertainty exists in ethical dilemma. In a study of 27 master's-prepared nurses working in two clinical settings, Davis (1991) found that uncertainty was taken into account in the process of ethical decision-making. In a situation where there was a "trade off" between being ethical and being efficient, uncertainty might be reduced and this could hinder the ethical decision-making process. Davis further asserted that experience of repeated frustrations related to the time required to make a decision around dilemmas resulted in desensitization to aspects of the dilemma.

Although much of the public perception of ethical issues in nursing practice seems to focus on dramatic cases such as euthanasia, organ transplantation and in vitro fertilization, in the working world of nurses, these issues have only been a small part of their practices (Hooft, 1990). According to Hooft, nurses are frequently confronted with conflicts arising from different expectations which are governed by professional norms and institutional norms. This is indicated by conflict between the profession's relational notion of caring and the institution's operational notion of caring (Hooft, 1990; Jameton, 1977; Matejske, 1981). Curtin (1978) and Curtin and Flaherty (1982) identified two major types of ethical dilemmas in nursing: those relating to hospital policies and doctors' orders

and those relating to the authority of nurses.

Code of Ethics

The American Nurses' Association 's Code for Nurses (Appendix I) has been designed as a guide for nurses to make ethical decision in nursing practice (Gaul, 1987). It addresses ethics related to biomedical issues, the nurses' obligation to society and profession, and protection of clients from incompetent and unethical practice.

The Code encompasses seven essential values for professional nurse which are altruism, equality, aesthetics, freedom, human dignity, justice, and truth. (American Nurses Association, 1985). These values are largely grounded in the ethical principles of autonomy beneficence, nonmaleficence, justice, veracity, confidentiality and fidelity. Among these principles, beneficence, the duty to do good and avoid harm is the foundation of the Code for Nurses.

The Code is universal in nature and it directs nurses to provide care that is independent of personal values which could be related to the social status of the client or the nature of the illness. It is the responsibility of each individual nurse to incorporate the tenets of the Code into nursing practice.

However, being knowledgeable about the Code does not equate with one's ability to make ethical decision. While it sensitizes the nurse to the ethical issues and provide direction, the Code does not supply answers to the problems (Stoll, 1989). It has been evident that the Code is not the primary basis for ethical decision. Instead, the personal professional value and the values of the employer have more impact on the ethical practice of the nurses (Cox, 1985/1986).

Ketefian (1981) asserted that without formal training, ethical choice is highly individualistic and intuitive. Ethical decision-making requires daily exercise in practice and nurses must be prepared to recognize them, to analyze them and to have the confidence to act upon the analysis of the situation (Steinfels, 1977).

Moral Development

Kohlberg (1968) documented the relevancy of the cognitive-developmental approach to the study of moral judgment. According to Kohlberg, individual's moral reasoning about moral choice reveals the structure of the individual's moral judgment. Based on the stage theory of cognitive development, Kohlberg developed a typology of moral reasoning that includes three moral levels with six moral stages and these stages are in hierarchical and sequential order.

In the first "preconventional" level of moral reasoning, morality is externally enforced by authority. Stage one within this level is characterized by a punishment and obedience orientation. At stage two, elements of fairness are interpreted in a pragmatic way and whatever provides personal satisfaction is considered as the right action. The second 'conventional' level is characterized by a desire to maintain social order and societal needs and values take precedence over personal interests. This level includes stage three, the 'good boy-nice girl' orientation where pleasing and bringing approval from others is considered as good behaviour, and stage four, the law and order orientation, where social order should be maintained and supported. The last 'post-conventional' level is characterized by internalized moral principles. This level includes stage five, the social contract, legalistic orientation where authority of social regulation is

accepted on condition that it has maximum social welfare. Finally, stage six, the universal principle orientation is the highest level of moral reasoning, where ethical principles that appeal to logical comprehensiveness, universality and consistency have authority over all external consideration. Murphy (1977/1978) demonstrated that most of the baccalaureate graduate nurses in her study were at 'conventional level' which emphasizes obedience to authority and the need to maintain harmonious relationships with institutions.

Kohlberg (1971) stated that intellectual development, social environment and educational climate are three crucial factors that affect moral development. Of the three factors, environment that encourages group participation, shared decision-making and accountability of action tends to stimulate moral judgment development. When individuals are challenged with moral dilemmas and presented with solution and arguments on stage above the highest level attained by the students, transition from one stage to the next is most likely to occur (Enright, Colby & McMullin, 1977). In Kohlberg's model, a moral dilemma is identified before moral reasoning is initiated, and the result is a moral decision (Stoll, 1989).

Moral Reasoning and Moral Behaviour. Although much of the nursing literature is based on Kohlberg's model to explain nurses' moral reasoning, it has been challenged on several points. A fundamental criticism is that Kohlberg examines moral reasoning but not moral action (Callery, 1990). Kohlberg's moral stages do not seem to be related to any specific course of action. In fact, the same general criteria, such as importance of punishment, value of trust and

loyalty can lead to opposite action depending on how a situation is evaluated (Blasi, 1980). In other words, the same behaviour can be supported by different moral criteria and the same moral criteria can lead to different moral behaviour. Since it is impossible to predict moral behaviour from moral reasoning, one could further argue that individual's hypothetical choice to a dilemma situation does not necessary lead to same action in real life (Rest, 1979). In a critical review of literature related to moral cognition and moral action, Blasi (1980) concluded that cognition is not the only determinant of behaviour. An affective dimension such as fear and anxiety which is often present in ethical decision, together with the individual's attitude and value should also be integrated to the study of the relation between cognition and action.

Ketefian (1981) investigated the relationship between moral reasoning and moral behaviour by comparing scores on the Defining Issues Test (DIT) with scores on Judgments about Nursing Decisions (JAND) developed by the investigator. The DIT is a multiple-choice questionnaire devised by Rest (1979) based upon the assumptions of Kohlberg's theory. It measures various aspects of moral reasoning and has been widely used in ethical studies. JAND scale measures nurses' perception of ideal and realistic moral behaviour. The results of Ketefian's study showed a significant positive relation between moral reasoning and moral behaviour. However, it was indicated that nurses' knowledge and value of idealistic moral behaviour did not seem to lead to same action in reality (Stoll, 1989). Ketefian proposed that the result could be a reflection of the "shock" experienced by new graduate nurses upon entering the bureaucratic health care system (Kramer, 1974). Such system might force nurses to change the

professional value in order to gain acceptance to the organization (Ketefian, 1981).

Crisham's (1981) study on the differences between nurses' responses to hypothetical moral dilemmas and real-life nursing dilemmas indicated that the level of education was clearly related to the level of moral judgment about the hypothetical moral dilemmas in the DIT. Results of the real-life Nursing Dilemmas Test (NDT) showed that responses to familiar dilemmas were more conscious and deliberate than responses to unfamiliar dilemma. It was suggested that previous encounter with similar dilemmas enhanced principled-thinking and facilitated judgment of moral issues as measured by the NDT.

Decision-making Framework

It has been asserted that decision making is a complex process which involves consideration of external (non-cognitive) factors and internal (cognitive) factors. Based on this concept, Bower (1982) suggested three main factors in approaching decision-making :

(1) The context or setting in which the decision is to be made;

(2) the value, attitudes and motivations of the decision maker; and

(3) the nature and characteristic of the decision to be made.

By accepting Bower's model, French (1989) adopted an information processing approach to the study of decision-making. The cognitive process, the problem itself and the effect of context on both of them were being explored in his study. The cognitive elements identified in the decision-making process are:

(1) Defining the problem (Gelatt, 1962);

(2) collection of information (del Bueno, 1983);

(3) generation of alternatives (Bailey & Claus, 1975);

(4) estimation of consequences of each alternative (Gelatt, 1962) and

(5) selection of alternative (Bailey & Claus, 1975).

Ethical Decision-making in Nursing

According to Steele & Harmon (1983), the persons individual values determine the choice of action in ethical decision-making. When personal value is in conflict with values of another person or institutions, a reasoned, logical approach based on moral principles rather than learned values should be adopted in solving the conflict. It is also important that the ethical judgment is based on "thought and reflection (higher level of moral reasoning) rather than the lower-level processes of intuition, self-interest or pragmatic considerations". (Ketefian, 1988, p.17)

Sigman (1979) assumed ethics is a component of most decisions which are influenced by values, beliefs, personal philosophy as well as knowledge and past experiences. He described ethical choice as decision made to benefit the client and made rationally. It is a moral obligation and the motivation for the behaviour is internal. Sigman identified three conditions of ethical choice,

(a) a need to act in a conflict situation;

(b) a moral principle is needed;

(c) the choice is rational.

Sigman's analysis has been criticized as failure to make connection between values and rationality (Finch, 1986). Very often, one cannot explain one's

value in a rational way and ultimately, the decision is a matter of preference. And the best the person can do is to build the best justification for his choice.

Martin's (1978) interactive approach to ethical decision-making provides a systematic understanding of a dilemma situation and thus allows one to gain more insight into ethical decisions. According to this approach, values hold a significant position. The decision-maker collects objective facts about the situation, which consists of information about the values and expectations of the client as well as personal values and expectations. Before making a choice, the decision-maker processes this information in the intellect in order to gain a better understanding of the situation and its meaning for that person's moral ideals. Thus, both the facts about the situation and the value-orientations which create the situation are considered. When a decision is made, an individual will continue to reflect upon the effectiveness of the decision. By this process of reflection, the decision maker tries to determine if the client's value-orientation might be different from his own and whether his decision is promoting or threatening his moral ideals. With this self-knowledge and knowledge of the client, the decision-maker makes more systematic revision of his judgement. The interactive nature of a complex ethical decision is well recognized in this approach.

Grundstein-Amado's (1992) model for clinical ethical decision making is composed of three major elements. The first component is the ethical framework, which is made up of ethical principles and theories. The second component is the decision-making framework which is composed of eight steps as follows: "(a) problem perception, (b) information processing, (c) identification of the patient's preferences, (d) identification of the ethical issues, (e) listing of

possible alternatives, and (f) their consequences, (g) the selection of a chosen course of action, and (h) its justification." (Grundstein-Amado, 1992, p.130) The third component is the contextual factors which are made up of (a) the relationship between the patient and the nurse and (b) the impact of organizational structure on the ethical behaviour.

Ethical Decision-making and Work Environment

Gaul (1987) suggested that ethical decision-making in nursing was complicated by issues of bureaucracy, autonomy, status and power. Although decision implied that one had a freedom to choose without undue coercion (Curtin, 1978), being an employee who had to be accountable to various health personnel, the nurse was not often in the position of a free agent. According to Jameton (1977), nurses had many responsibilities but they had little authority and power to make free ethical choices. Instead of exercising what was described as ideal moral behaviour, they were very often caught in the middle of ethical conflicts under a bureaucratic hierarchy.

It was also found that the perception of autonomy in work environment was positively related to ethical judgment when intelligence was controlled (deJong, 1984/1985). Cox (1985/1986) indicated that perceived powerlessness was negatively related to ethical decision. His study also demonstrated that personal value, role of employer rather than code of nursing ethics influenced the ethical decision. Erlen's (1991) study further confirmed that perceived powerlessness was a common experience of nurses. The findings also suggested that nurses were unable to use their clinical knowledge and expert power to resolve the

identified ethical dilemma. However, the findings of Finch (1986) showed that nurses' perception of work environment had no effect on the ethical behaviour.

Hofling (1966) set up an experiment in which an telephone order of drugs dose which was twice the recommended dose was given. Nurses in this study were placed in a situation in which no information about the medication was given. The findings showed that 21 out of 22 nurses actually followed the doctor's order without questioning despite the fact that the drug was overprescribed and should not be taken by phone. The experiment demonstrated that under the pressure of the context of authority-subservient relationship, blind obedience to the extent of endangering life could have happened. Eleven years later, Rank and Jacobson (1977 cited in Finch, 1986) did a replication study of Hofling. Different from Hofling's study, nurses in the second study had access to information about the medication such as drug references, consultation with pharmacists and peers. The results were reversed and 16 out of 18 nurses refused to give the drug. The findings of these two studies demonstrated that work environment especially, nurses' relationship with peers influenced ethical decision-making.

Ethical Decision-making and Role Conception

The findings of Holly (1986) and Swider et al. (1985) suggested that perceived role constraint might be a factor influencing nurses' ethical decision making. The majority of nurses in their studies exhibited a bureaucratic rather than a patient or physician orientation to ethical decision-making. Moreover, when nurses were uncertain and confused about the appropriate role of the nurses,

they might perceive themselves to be powerless in making effective ethical decision.

Ketefian's (1985) study on role conception indicated that the professional actual role conception and bureaucratic role discrepancy was positively correlated while professional ideal role conception was negatively correlated to ethical decision. It was reminded that the actual professional role conception was a better predictor of the ethical decision making than the ideal one and the findings of the study should be viewed as suggestive rather than definitive.

Ethical Decision-making and Education

Although it has been a common belief that education promotes ethical decision making, there is a lack of significant differences in scores on ethical decision making and educational level (Cox, 1985/1986; Gaul, 1987; Swider, et al., 1985). Two studies found no relationship on ethical choice for students who had received ethics instruction in nursing curricula when compared with a control group (Gaul, 1987; Hustead, 1983).

The lack of significant differences between student groups in the above studies could be due to relatively little experience with ethical matters across the groups. The findings of a national survey carried out by Cassells and Redman (1989) on both generic students and post-registration students who were studying for the baccalaureate suggested that previous experience in dealing with ethical issues or ethical conflicts in nursing care might facilitate ethical decision-making process. Therefore, exploration of a particular previous experiences instead of nursing experience in general may be a more relevant approach.

Crisham's (1981) study on nurses' responses to real life nursing dilemma verified that the master's-prepared expert nurses scored highest on the Nursing Dilemma Test when compared with other 4 subjects groups, staff nurses with associate degree, baccalaureate degree, college junior prenurse and graduate level nonnurses. Nurses with more clinical experiences also scored higher on the similar test.

Learning Climate

Concept of Organizational Climate. The climate, or atmosphere of the hospital ward, the role of ward sister and ward staff in relation to student learning in the ward has been the central theme of some nursing literature (Bendall, 1975; Revan, 1964; Fretwell, 1978). Although the notion of climate as an explanatory concept to student nurse education was expressed in these nursing literature, as Orton (1981) argued, the concept of climate was neither well-defined nor adequately developed with empirical evidence in these research studies. It was not until 1981 that the concept of climate in organizational psychology was adopted to the exploration of hospital ward situation. Based on this concept, the notion of ward learning climate was developed and it was found to exist as a measurable reality for student nurses (Orton, 1981).

Organizational climate has been the domain of social psychology which emphasizes individual's perception of the organization and their cognitive and affective responses to the organization (Moran & Volkwein, 1992). It consists of feelings and reactions prevailing throughout a whole organization and is socially reinforced through face-to-face interactions (James & Jones, 1974).

Organizational climate affects one's behaviour by defining the stimuli encountered by the individual, putting constraints upon the freedom of choice of behaviour and rewarding and punishing behaviour as its consequence (Forehand & Gilmer, 1964). Pritchard & Karasick (1973) viewed organizational climate as a psychological environment which has a potent effect on human behaviour. It serves as a basis for interpreting the situation and acts as a source of pressure for directing activity.

By incorporating elements of the above definitions, Moran and Volkwein (1992) offered a comprehensive definition of organizational climate. Organizational climate is a relatively enduring characteristic of an organization which differentiates it from other organizations. It includes members' perception about their organization and reflects the prevalent norms, values and attitudes which emerge through interaction among members. Since it influences and shapes behaviour, it could be served as a basis for interpreting the situation.

Some researchers contend that the concepts of organizational culture and organizational climate have been frequently accepted in organizational theory as if they were synonymous (Schneider, 1985). Schein (1985) defined organizational culture as " the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel as related to those problems" (p.3). To Schwartz & Davis (1981), organizational culture is a pattern of beliefs and expectations shared by the organization's members. Norms within the culture

have a powerful impact on shaping the behaviour of individuals and groups in organization. In summary, organizational culture is a system of shared assumptions, beliefs, values and norms which shape the attitude and behaviours in an organization.

Organizational Climate and Leadership. Many evidences have shown that leadership style contributes significantly to organizational climate (Litwin & Stringer, 1968; Cheng, 1985, 1986). According to Litwin and Stringer, an supportive and goal oriented climate led to high production performance, high job satisfaction and work innovation. Similar results were found in Cheng's (1986) study when the schools were open and led by principals who encouraged initiating structure. Cheng's findings also suggested that leadership influences organizational climate of the school especially when the principal sets a hard working example, considers needs of the teachers and show friendship, trust and respect to the teacher. Leadership behaviour such as allowing subordinates more participation in decision-making and encouraging two-way communication have also been important determinants of employee performance and effectiveness (Orton, 1981).

Ward Wearning Climate

It has been stipulated by the Nursing Council for England and Wales that the staff nurses from all wards should provide teaching and supervision to student nurses (General Nursing Council, 1983). It is further emphasized that wards and department available for training should offer " a good climate for learning"

which includes criteria such as the identification of learning objectives and ward sister be the assessor.

The most comprehensive study of ward as learning environment by Fretwell (1982) focused on assessing the "learning content" of various ward situations. According to Fretwell (1982) the ward learning environment "is not a static concept, but the outcome of inter-relationships of elements which are constantly changing. It encompasses the different social groups in the ward and the relationship between them" (p.25). From his study of 87 subjects in 14 training wards, Fretwell concluded that the ward sister was the key person in the learning environment and an ideal sister was democratic, patient-oriented and willing to teach.

Orton's (1981) described ward learning climates in terms of two extremes, low student oriented (LSO) and high student oriented (HSO) wards and they were dependent on the behaviour of the ward sister. Those wards that were described as (HSO) displayed a strong association between ward experience and student nurse satisfaction. They had high level of team work and consultation and the ward sisters were more sensitive to the needs of subordinates. The ward sisters also devoted more time to teach students. Both students' and patients' emotional and physical needs were reported as being met in those wards. Conversely, students on LSO wards displayed much less job satisfaction.

Reid's (1983) study suggested a 'better' ward for learning. Those 'better' ward had more experienced and older staff. There was much higher contact time between the staff and students and the clinical teachers were more experienced ward sister. Teachings in these ward were also more patient-centred and

performance of students was significantly better. Revan (1964) investigated the influence of ward sister's attitude on students and the findings indicated that 'good ward atmosphere' was associated with more effective communication and better patient care. Morale in these wards were high and nursing staff more stable.

Ward Teaching and Learning. The National Syllabus of United Kingdom and literature indicate that clinical practice is a valid and learning experience (Brigg, 1972; Pepper, 1977; Alexander, 1980). A opinion survey by French (1989) indicated that clinical practice which took up the largest part of the nursing training provided the most relevant learning experience to the students. Yet, the teaching in wards was most poorly organised. The learning process in wards was often stifled by inadequate teaching and supervision, poor working relationship and disinterest in students. The peer students became the significant physical and emotional support especially during the first year of the training. The ward sister was the predominant figure in their minds and patients only came to their concern when poor nursing practice occurred (French, 1989).

Orton (1981) and Marson (1982) also demonstrated that individual learning needs and opportunity of students were ignored. Much of the teaching, if it occurred, was confined to task-related area. Specific procedures and techniques were the most common learning items uppermost in ward sisters' mind for students (Fretwell, 1982; Marson, 1982). However, such technical nature of nursing activities was reckoned by student as "work" rather than "learning" (Fretwell, 1982). Very often, they were expected to perform a task without much further supervision after they were shown about the task once. Results of

the Jacka and Lewin's (1987) study indicated that students worked alone in more than half and some even more than 75% of their time in their practice. It is not hard to imagine that an incorrect practice can be easily left undetected and the student can just continue to practice incorrectly.

Role of Ward Staff and School Tutor in Ward Teaching. Bendall (1975) and French (1989) asserted that nurse tutors who were supposedly most experienced in teaching seldom visited the ward and they were ranked low as a preferred teachers by students Ironically, the appearance of nurse tutor on wards was considered as a surprise to both students and staff nurses (Dodd, 1973).

It was reported that ward sister and staff nurses were the most available and appropriate teachers in the clinical practice (Marson, 1981; Alexander, 1980). However, these qualified staff were rarely given any formal training on teaching. In fact, students learned most from their peer and senior students (Bendall, 1975; French, 1989). From these research findings, it is not difficult to see that a large part of student learning is relying on individuals who have not been prepared for teaching.

Fretwell (1978) and French (1989) reported that staff nurses were considered as unapproachable and unfriendly to students. Similar studies also indicated that many students expressed dissatisfaction with interpersonal relationship on wards (Birch, 1975; Fretwell, 1978; French, 1989). It was evident that staff nurses' responses to students' questions had been generally unfavourable (Dodds, 1979; Fretwell, 1978)

Many research findings have shown that the clinical practice is a highly

stressful experience for nursing students especially during the first 6 months of training (Parkes, 1980). Students report high level of work pressure but little support from ward staff. High anxiety level and depression is also a common phenomenon. Yet in time of emotional distress, students tend to seek support from fellow students rather than ward staff and tutors.

In order to rectify this unsatisfactory situation, the post of clinical teacher was introduced. Unfortunately, this system has proved to be inefficient since the time spent on each student is limited when working on a one-to-one basis. At present, the United Kingdom and English National Board are recommending the phasing out of clinical teachers. Instead, an identified mentor on each ward responsible for facilitating learning and support during the clinical experience is recommended (Marriott, 1991).

Role of Ward Sister in Ward Teaching. Several important studies related to the quality of ward learning have strongly suggested that the ward sister is perceived as the most influential person in creating and controlling the ward learning environment (Orton, 1981; Ogier, 1981; Fretwell, 1982; Smith, 1988). It is not only her own commitment to teaching but also her organization of the ward work, her leadership style and patterns of relating to others which turn a ward environment into a learning one. Orton's (1981) High Student Oriented sister was observed to spend more time to teach students than the Low Student Oriented sisters.

A more recent comprehensive assessment of the pre-registration preparation of nurses undertaken by French (1989) also concurred with the above findings

on the effect of ward sister leadership and teaching behaviour on student learning. French's findings demonstrated the ward sister was perceived by student nurses as the most significant person in setting a ward climate conducive to learning. It was evident that the sister influenced the student learning directly by her relationship and attitude to the student and indirectly, by the way she managed the nursing team. Her attitude and skill were then transmitted to her team members. In French's experimental testing of effect of ward sister behaviour on student's problem solving ability, he confirmed that student nurses who were exposed to high student oriented behaviour made more patient-centred decision than those exposed to low student oriented behaviour. It was further evident that in making clinical decision, both the needs of their seniors and the patient were consistently taken into account by the student nurses.

Ogier's (1981) study indicated that 'good' sisters devoted more time interacting verbally with students than with others such as doctors and patients. The findings of Smith's (1988) study showed that the approachability of ward sister was most important to students and the provision of learning opportunities was more important than formal teaching.

Wards which practised patient allocation instead of task assignment were perceived as more conducive to learning needs of students (Orton, 1981). Ward sisters also provided learning opportunities not only relevant to students' but also patients' individual needs (Fretwell, 1983). The results of the literature cited above have shown that the influence of the ward sister extends beyond the actual teaching that she does.

Relationship among Role Conception, Ethical Decision-making and Learning Climate

The result of French's (1989) experimental study on the effect of sister's behaviour on the decision making of student nurses confirmed that students who were exposed to high student oriented behaviour made more patient-centred decisions than the group who were exposed to low student oriented behaviour. It was further confirmed that students after the first year had a predisposition to be patient-centred. This predisposition could be enhanced or inhibited by behaviour of those who controlled the learning climate. It was further asserted that students might develop habitually high or low patient oriented decision-making patterns. This depended on how frequently the decision was made in actual practice.

The study further demonstrated that when the students made decisions about a clinical problem in which they were unsure of the expected behaviour, students would often consider the possible responses of their seniors first rather than the needs of the patient. This indicated that students might develop a habit of making decision to please or at least not to contradict the seniors. In other words, the needs of the seniors often took precedence over the needs of the patient. However, when the clinical problems were common and the responses were sure to be non-offensive to the wishes of the seniors, the needs of the patient would take precedence (French, 1989). It was illustrated that such dependency on the response of the senior could result in a habit of making low patient-centred decisions.

Wiles' (1981) study on the socialising effects of the first ward allocation

upon the student nurses also demonstrated a positive change in individualized care for students who were exposed to a patient-centred ward and negative change for students who were exposed to a task-oriented ward.

In the face of an ethical dilemma which presents a certain degree of risk and uncertainty, these same student nurses might tend to make decision which is less ethical. For those final year students who have undergone a longer period of exposure to a low student oriented behaviour and bureaucratic socialisation, their decision on ethical dilemma would be presumed to be less ethical than those first year students who have only been exposed to the institutionalising process for a short period of time.

However, for the final year students who have been more experienced with patient care and more familiar with ward environment, they might be more capable to assess the consequence of an action and make decision more independently than their first year counterparts. This, therefore, might counteract the aforementioned negative socialization effect on students' ethical decision-making and lead to better ability to resolve ethical dilemmas in these graduating students.

Pieta's (1976) study on role conception among nursing students, faculty members and head nurse showed that baccalaureate degree students scored higher in the actual service role conception than the diploma and associate degree students. For the service role discrepancy, the baccalaureate degree students had the greatest and the diploma had the least score. According to Corwin (1960), service role conception is the most stable one among the three types of role conceptions. Therefore, it is expected that there will be no significant difference

in scores of the service role conception between the two groups.

The findings of Ketefian's (1985) study on role conception and moral behaviour demonstrated that the higher the professional actual score, the higher the moral behaviour. It was also suggested that while students were engaged in study, they experienced changes in their role conceptions and underwent professional socialisation. Yet, these changes were not enduring but subjected to change within the context of the bureaucratic work setting. It was also evident that professional role discrepancy had a negative effect on moral behaviour.

Therefore, it is argued that the final year baccalaureate students will have a lower score in professional role conception than their first year fellow students but a higher score than the certificate students who spend majority of their training time in ward being socialised into a more bureaucratic role conception. It is also asserted that the first year certificate students will score lower in bureaucratic role conception score than their senior fellow students as their exposure to bureaucratic mode of operation is still limited.

The interrelationship among the ethical decision-making, the role conception and ward learning climate is summarized in the proposed model shown in Fig. 1. The literature studies revealed that the educational process plays an important role in the development of one's role conception. Value and attitude which are acquired through the socialization process of education shape individuals' role conception and influence their ways of resolving a dilemma situation. Students' perception about the context of the ward environment reflects the prevalent norms and value which have a powerful impact on shaping students' behaviour towards patient care (Moran & Volkwein, 1992).

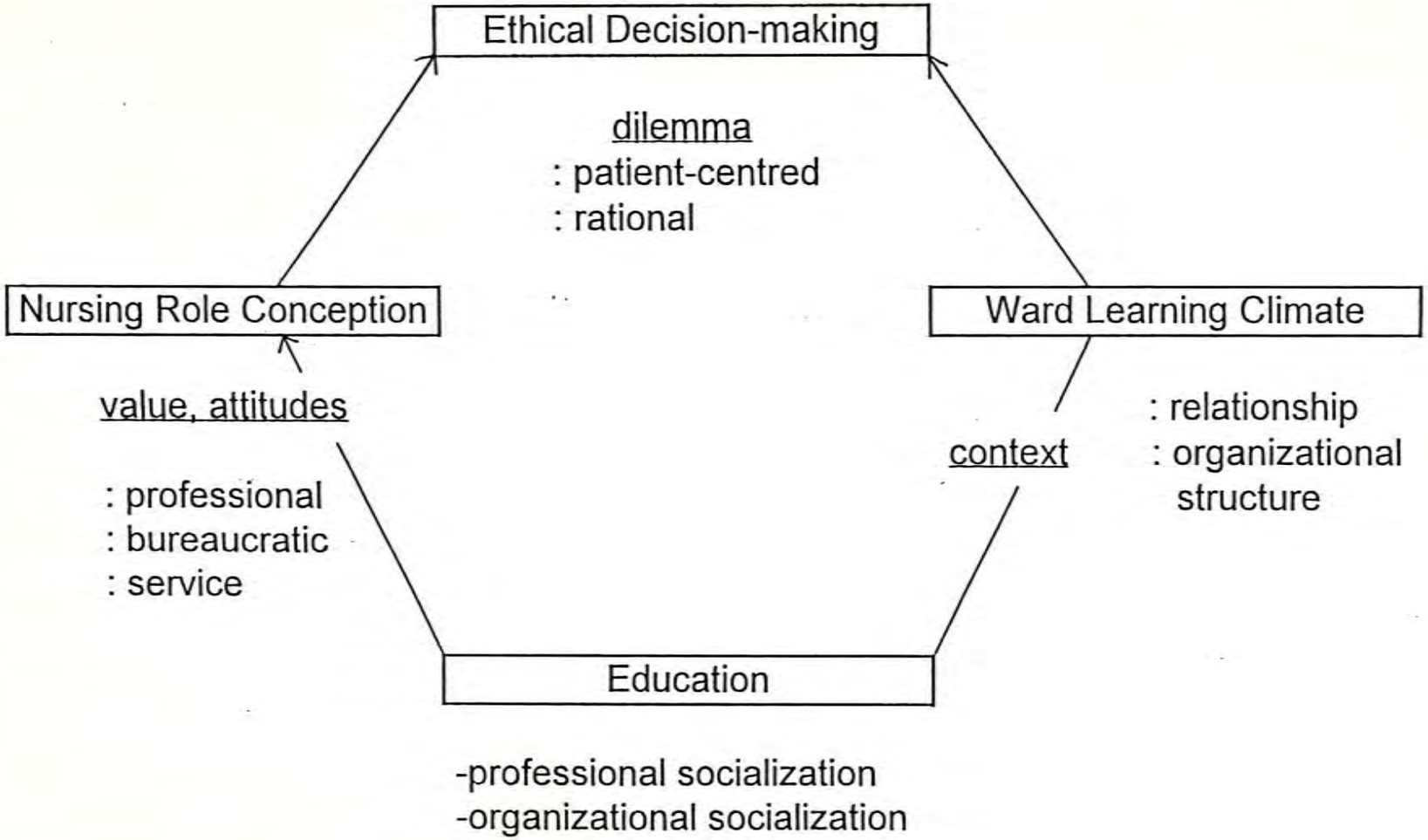

Figure 1. Proposed model for the interrelationships among ethical decision-making, education, role conception and learning climate.

CHAPTER 3

RESEARCH METHODOLOGY

Design of the Study

The present study was a cross-sectional survey. It aimed to reveal the relationships among the education background, role conceptions, ethical decision making and the ward learning climate.

Hypotheses

1. There is a significant difference in the three role conception types among students in the three cohort groups and those in the two types of nursing educational programmes.
2. There is a significant difference in each of the three discrepancy role conception types among students in the three cohort groups and those in the types of nursing educational programmes.
3. There is a significant difference in ethical decision-making among students in the three cohort groups and those in the two types of nursing educational programmes.
4. There is a significant difference in the perception of ward learning climate in the three cohort groups and those in the two types of nursing educational programmes.
5. Appropriate ethical decision making is positively related to the three types of role conceptions and ward learning climate among students in the two types of nursing educational programmes.

Definitions

1. Role Conceptions is the set of role expectations for nursing as perceived by student nurses in the study and as measured by the Bureaucratic, Professional and Service Role Conception Scale.

   Ideal Role Conception is the set of role expectations which the participants perceive should exist in the practice of the nursing.

   Actual Role Conception is the set of role expectations which the participants perceive to be practised in nursing.

   Role Discrepancy is the extent to which the perception of the ideal role conception differs from the perception of the actual role conception. In operation term, it is the difference between the score of "should" question and "is" question.

2. Bureaucratic Role Conception requires loyalty to the hospital and hospital administration and to the routine work; the nurse's job description is defined by rules, policies and regulations within a specific hospital; values strict adherence to rules, routine and punctuality.

3. Professional Role Conception requires loyalty to the profession and occupation principles; emphasizes active participation and membership in the professional association and commitment to formal knowledge and continued learning.

4. Service Role Conception requires loyalty to the patient; considers nursing as a calling to serve the patient in dedication and compassion; emphasizes humanitarian service.

5. Ethical Decision-making refers to the actions which reflect nursing behaviour advocated in the American Nurses Association (ANA) Code of Ethics. A high score in the JAND scale reflects consistency between ethical practice and ethical nursing actions (Ketefian 1981).

6. Ward Learning Climate is the nursing student's perception of the ward learning experience in terms of two dimensions- the high student orientation and low student orientation.

Subjets

The sample consisted of nursing students from two types of nursing educational programme: (1) the hospital-based certificate nursing training programme (certificate) and (2) baccalaureate degree nursing education programme (degree). Following closely to the British tradition, the nursing school of the certificate programme was attached to a hospital and students were part of the work force for the hospital service. The programme which was based on a common syllabus approved by the Nursing Board of Hong Kong requires only 38 to 42 weeks of theory conducted within five study blocks. The duration of each study block ranged from 6 to 12 weeks and remaining time was spent in the wards of the same hospital. The ward rotation was between 4 to 8 weeks (Childe, 1992). Due to lack of a hospital as a home base for clinical attachment, students from the degree programme have to rotate to different wards of different hospitals for a short duration (2-4 weeks) throughout the programme for clinical experiences.

The students selected from the certificate programme were from the first study block, third study block and fourth study block. For comparison, the second, third and fourth year students from the degree programme were selected. Three cohort groups were formed according to their clinical experience and they are shown as follows:

Cohort group		Clinical experiences
1	Certificate 1st study block	about 640 hours (after 1st clinical practice)
	Degree 2nd year	about 160 hours
2	Certificate 3rd study block	about 1357 hours (after 3rd clinical practice)
	Degree 3rd year	about 1040 hours
3	Certificate 4th study block	about 2319 hours (after 4th clinical practice)
	Degree 4th year	about 1752 hours

One hospital offering the certificate programme and one institution offering the baccalaureate programme were conveniently selected. Both programmes had similar numbers of hours of ethics course conducted for the students. The hospital was a public acute hospital with about 700 beds. It was a teaching hospital providing clinical experience for her own nursing students and those from the degree programme. A total of 145 students from the certificate and 82 students from the degree programme were selected mainly on a voluntary basis. Since there was only one institution offering the degree programme and no clinical practice was offered until second year, the first year students for this group was not selected.

Procedure

Permission for access to students was obtained through initial contact with the administrator of each programme (Appendix. II). Final permission was obtained from the ethics committee of each institution. With the approval, the author conducted the questionnaire in person to the students. For the certificate students, the questionnaire was administered in a classroom during the last week of their study block. Due to the tight schedule of the programme, the school could only allot the time for the author to conduct the questionnaire after the last class of the day. For the degree students, the questionnaire was administered in the free time between their classes near the end of the first term. At the time of the meeting, purpose of the study and procedures to ensure confidentiality was explained to the students (Appendix. III). Those students who volunteered to participate were asked to read the cover letter (Appendix. IV) and to sign the consent forms (Appendix. V). Completion of the questionnaire including the demographic form (Appendix. VI) required less than an hour.

The response rate of the participation was 100%. However, of the 227 questionnaires returned, only 221 were usable. Any questionnaire with more than 7 unanswered items in one of the story in the JAND scale was discarded.

Instruments

1. Role Conception Instrument

The instrument used in this study was based on the role conception scale developed by Pieta (1976) whose questionnaire was originally based on Corwin's (1960) scale. Corwin's original questionnaire consisted of three role conception

scales-- professional, bureaucratic, and service and they were modified and adopted for this study.

Professional role conception measures characteristics such as commitment to knowledge as the basis of a profession, to judgment ability in nursing care, to the upholding of professional standard and to active involvement to professional association. Bureaucratic role conception items measure characteristics which indicate loyalty to hospital bureaucracy, such as punctuality, strict adherence to rules, the importance of tenure and loyalty to authorities in control of the hospital. Service role conception emphasizes such ideals as service to humanity, a willingness to be patient-centred and a desire to do "bedside" nursing (Corwin 1961a).

Scoring of the Instrument. The three role conception scale consisted of eight professional item, eight bureaucratic and seven service items (Appendix. VII). The items in each scale were composed of a hypothetical situation in which a nurse might find herself. For each situation, there were two questions: Question A asked the respondent to indicate the extent to which she thinks the situation should be the ideal in nursing and Question B asked the respondent to judge the extent to which the situation was happening at the hospital. For each question respondents were asked to indicate one of the alternative responses ranging from "strongly agree", "agree", "undecided", "disagree" and "strongly disagree". The Likert-type of response alternative was scored from 1 to 5 with "strongly disagree" as '1' and "strongly agree" as "5".

The arithmetic sum of the item responses in question A constituted the total scale score of ideal role conception and the same scoring method for question B which constituted the score of actual role conception. By subtracting the actual score from the ideal score, a difference score yielded the role discrepancy score. Positive role discrepancy scores indicated the situation was perceived as not existing to the extent that the respondent thought it should. Negative scores indicated that the perceived situation existed to a greater extent than the respondent thought it should.

It could be assumed that the actual role conception was the reflection of what was being practised in hospital but only the respondents' judgment of the extent to which the situation was happening in the hospital.

Validity and Reliability of the Instrument. Pieta (1976) modified the Corwin instrument by revising some of the hypothetical situations. Twelve more items were added to the scale to improve the reliability estimates. The content validity was determined by a panel of nurse experts with experience in teaching nursing and administration. Only situations that were selected at least 75% of the time were retained. Based on Kramer's (1966) "known groups" method, three groups of nurses: collegiate nurse faculty, service administrators, and nurses with religious commitments were selected to test the predictive validity of the instrument. As predicted, of the three groups, nurse faculty scored highest on the professional role conception, nurse administrators the highest on the bureaucratic and nurses with religious commitments the highest on the service role conception scale. The Cronbach reliability coefficient on the professional scale

was .84, .63 for the bureaucratic and .58 on the service scale (Pieta, 1976).

Since some situations related to professional and bureaucratic scale mentioned in the Pieta's instrument would not be applicable to the situation in Hong Kong, the instrument used for this study was modified by the author based on her experience. Only those situations relevant to Hong Kong were selected and additional situations were developed resulting in a total of twenty three situations (Appendix. VIII(A)). The format, the three role conceptions, and the scoring method used in Pieta's scale remained the same. Since items on professional and bureaucratic role conceptions were modified, the validity of the instrument was tested again based on the aforementioned "known group" method. As predicted, results showed significant difference between the nursing faculty and administrators with the former score highest on the professional scale and the latter highest on the bureaucratic.

The Cronbach reliability coefficient for each role conception scale of the revised instrument for the present study was .65 for the professional, .77 for the bureaucratic and .64 for the service.

2. Ethical Decision-making Instrument

The Judgment About Nursing Decisions (JAND) instrument used in this study was developed by Ketefian (1981) and it has been the second most widely used instrument by nurse researchers in measuring ethical behaviour. The instrument measured two dimensions of ethical decision making: professionally ideal ethical making (column A) and realistically likely decision making (column B). The Code for Nurses (American Nurses Association, 1985) was used as

the standard for assessing the extent to which nursing actions were ethical or not (Ketefian, 1981,1982).

The JAND scale consisted of six stories depicting nurses in ethical dilemmas which commonly occur in general nursing practice. Each story was followed by a list of six to seven nursing actions and respondents were asked to respond " yes" or "no" twice to each action. First, whether they think the nurse experiencing the dilemma in the story should or should not engage in that action (column A) and second, what they think the nurse experiencing the dilemma is likely to do. (Appendix. IX(A))

Scoring of the Instrument. The correct answer to each nursing action was determined by a panel of professionally recognized nursing expert in ethics who rated each action according the ANA Code of Ethics. A score of 1 was assigned to an "appropriate" nursing action and 0 for an "inappropriate" nursing action. For each actions, respondents twice checked "yes" or "no": first, in column A and second, in column B. The score added together reflected the subject's score on ethical decision. A high score reflected a more ethical nursing action.

Items where "yes" is appropriate and where "no" is appropriate are indicated as follows:

Story Number	Items where "yes" is appropriate	Items where "no" is appropriate
One (6 items)	2, 4, 5, 6	1, 3
Two (7 items)	1, 2, 7	3, 4, 5, 6
Three (7 items)	1, 3, 4, 5, 7	2, 6

Four (6 items)	1, 3, 4	2, 5, 6
Five (6 items)	1, 4, 5	2, 3, 6
Six (7 items)	2, 3, 6, 7	1, 4, 5

Validity and Reliability of the Instrument. Content validity of the JAND scale was established and a representative sampling of the ethical dilemmas nurses commonly faced were included. All items in the tool were assessed and evaluated by nursing experts in terms of the extent to which each nursing action embodies the tenets of the Code. The tool was also significantly correlated with a known measure of moral reasoning - Defining Issues Test (DIT) developed by Rest (1979) (column A, $r = .28$, $p < .01$; column B, $r = .19$, $p < .05$). Given the lack of strong interrelationship among the items (internal consistency) in column A Ketefian (1989) cautioned that column A should not be used as a separate scale to hypothesis testing. For internal consistency, the Cronbach's coefficient alpha of column B ranged from .66 to .73 (Ketefian 1984). However, it was reminded that the score only reflected what the respondent's beliefs of what the nurse in the situation would do rather respondent's own actions. For the present study, both column A and B were used and the Cronbach 's coefficient alpha was .51 for column A and .63 for column B.

3. Learning Climate

The questionnaire used in this study to describe the characteristics of a ward learning climate was based on the one developed by Orton (1981). The two scales which reflected the key dimensions of ward learning climate were: "the

ward sister's recognition of student nurse needs"; the ward sister's commitment to teaching". Each scale was composed of cluster of items and the analysis of these items discriminated very significantly between "High Student Oriented"(HSO) and "Low Student Oriented" (LSO) wards. A HSO was characterized by high regard for students as learners rather than workers; patient allocation rather than task allocation; high cohesion in team work and high morale; ward sister's commitment to teach and wide experience for student learning. A LSO ward was characterized by lack of concern for the well-being of subordinates; ward sister's low priority in teaching students; task oriented and uncaring and unfriendly environment.

It has been reminded that although the scales were able to measure the ward learning climate the correlation of each of them was not particularly strong. Therefore, based on a review of studies examining the ward learning climate, a questionnaire with 36 items selected from the original 109-items Orton's questionnaire was developed to measure students' perception of the characteristics of a ward learning climate. The revised questionnaire consisted of 36 items and were grouped under the five key factors (Appendix. X): "involvement in teaching", "task/patient orientation", " communication lines approachability", "emotional support" and "attitude to students" which were selected as part of the nine key indicators for HSO and LSO by French (1989).

The two open-ended questions: "what did you like best about the wards?" and "what did you like least about the wards?" which was demonstrated to yield vivid ward profiles in the original ward climate study of Orton (1981) were included at the end of the questionnaire.

Scoring of the Instrument. For each item, students were asked to indicate one of the alternative responses ranging from " strongly agree". "agree". "undecided", "disagree" and "strongly disagree" with a score "5" for "strongly agree" and "1" for "strongly disagree".

Mean scores for each indicator were calculated. It was necessary to reverse the scoring of certain items so that all items were translated into positive statements for high student orientation wards (Appendix. XI(A)). For example, item 4 ('student nurses are sometime regarded as a nuisance when the ward is busy') was scored "1" for "strongly agree" and "5" for "strongly disagree". The arithmetic sum of the items was computed.

For the two open-ended questions, content analysis was performed by first reading through the responses for emerging patterns. Coding was given for each pattern identified and the frequency of responses mentioning each pattern were counted and analyzed.

Validity and Reliability of the Instrument. Content validity of the instrument was established by nursing experts who were involved in the area of ward learning climate study. All items were assessed in terms of characteristics of each key indicator set out by French (1989). The instrument was administered to two groups of hospital-based student nurses in order to pilot it for clarity and ease of understanding. The group was comprised of 40 students in the first and third study block. The group reported that items were clear and easy to understand.

Cronbach coefficient alpha was computed to determine the internal

consistency of the six subscales. The internal consistency computed was: .38 for the "communication lines approachability", .58 for the "task/patient orientation", .55 for "teaching, .77 for "attitude to students" and -.00 for "emotional support". Due to low Cronbach alpha score,the "emotional support" subscale was deleted. However, item 32 of this subscale which was related to how ward sister communicated to subordinates was retained and added to the "communication lines approachability" subscale. After this modification, the internal consistency of the subscale became .72. For the four subscales, the results were similar to those of the pilot study.

As the mother tongue language of the samples were Chinese, all the three instruments adopted for this study were translated into Chinese (Appendix. VIII(B); Appendix. IX(B); Appendix. XI(B)).

Analysis Design

Data were analyzed with the SPSS (Norusis, 1992a,b,c) and the main statistical tests were as follows:

1. To evaluate the difference in the three role conception types among students in the three cohort groups and those from the two types of educational programmes, two-way ANOVA with the three role conception types as dependent variables and the three cohort groups and educational programmes as between groups factors was performed and analyzed.
2. To investigate the difference in the role discrepancy scores of each of the three conception types among students in the three cohort groups and two educational programmes, two-way ANOVA with the three role discrepancy

score as dependent variables and the three cohort groups and educational programmes as between groups factors was computed and analyzed.

3. To evaluate the difference in ethical decision making among students in the three cohort groups and those from the two types of educational programmes, two-way ANOVA with ethical decision making as dependent variable and the three cohort groups and educational programmes as between groups factors was conducted and analyzed.

4. To investigate the difference in the students' perception of ward learning climate in the three cohort groups and the two types of educational programmes, two-way ANOVA with the four learning climate variables as dependent variable and the three cohort groups and educational programmes as between groups factors was computed and analyzed.

5. To test the relationship among ethical decision making, role conception and ward learning climate, Pearson product-moment correlations and multiple stepwise regression with ideal and actual ethical decision making score as the criterion variables and the three role conception types and ward learning climate as the predictors was computed and analyzed.

CHAPTER 4

RESULTS

Demographic Characteristics

The distribution of respondents by level and stage of education is shown in Table 1. A total of 140 students were selected from the certificate programme and 81 students from the degree.

Table 1
Distribution of respondents by Types and Stages of Education

Type of education (group)	Stage of education (grade) Cohort			
	1	2	3	Total
Certificate	40 (1sb)	52 (3sb)	48 (4sb)	140
Degree	31 (2yr)	30 (3yr)	20 (4yr)	81
				221

Note. 1sb = 1st study block, 3sb = 3rd study block, 4sb = 4th study block
2 yr = 2nd year, 3 yr = 3rd year, 4 yr = 4th year

Demographic data, including age, and years of nursing experience were obtained for all students in the present study (Table 2). The ages of the respondents ranged from 15 to 44 years. For the certificate students, majority were between 20 and 29 years of age with 58% between 20 and 24 and 24% between 25 and 29 years of age. For the degree students, 96% were between 20 and 24 years of age. Of the total sample of 140 certificate students, 74% had no previous experience in nursing and twenty-one percent had between 1 and 5 years of nursing experience. For the total sample of 81 degree students, 95% had no previous nursing experience and only 5% had between 1 and 5 years of nursing experience.

Table 2
Demographic Characteristics of the Subjects.

Group	Characteristics		Frequency	Percent
Certificate	Age	15-19 years	13	9.3
		20-24	81	57.9
		25-29	33	23.6
		30-34	12	8.6
		40-44	1	0.7
	Pervious nursing experience	0 year	103	73.6
		1-5	29	20.7
		6-10	6	4.2
		11-15	1	0.7
		16-20	1	0.7
Degree	Age	15-19 years	1	1.2
		20-24	78	96.3
		25-29	2	2.5
	Pervious nursing experience	0 year	77	95.1
		1-5	4	4.9

Differences in Role Conception Types

To evaluate the difference in the students' role conception types, two-way ANOVA with the three role conception types as dependent variables and the three cohort groups and educational programmes as between groups factors was performed. The mean scores of ideal, actual and discrepancy role conception for the certificate and degree students are presented in Table 3. The result revealed that both groups perceived the ideal professional role (certificate $\underline{M}$ = 31.93, degree $\underline{M}$ = 33.32) should be practised to the greatest extent in nursing, the service role (certificate $\underline{M}$ = 29.38, degree $\underline{M}$ = 30.20) was next and the bureaucratic role (certificate $\underline{M}$ = 24.40, degree $\underline{M}$ = 23.57) was the one which should be practised to the least extent.

Table 3

Means and Standard Deviations of Ideal, Actual and Discrepancy Role Conception between Certificate and Degree Students.

		Role Conception																	
		Professional						Bureaucratic						Service					
		Ideal		Actual		Discrepancy		Ideal		Actual		Discrepancy		Ideal		Actual		Discrepancy	
Group	N	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Certificate	140	31.93	3.13	26.42	3.14	5.50	3.95	24.40	3.45	26.65	3.58	-2.23	4.57	29.38	2.83	22.65	3.82	6.78	4.44
1st study block	40	32.23	2.94	26.38	3.42	5.85	4.34	23.78	3.62	26.58	3.30	-2.80	4.82	30.23	2.90	21.85	4.27	8.38	4.89
3rd study block	52	30.98	2.94	26.08	2.60	4.90	3.15	24.42	3.02	26.37	3.28	-1.92	4.15	28.33	2.61	22.20	3.01	6.20	3.63
4th study block	48	32.65	3.27	26.81	4.11	5.83	4.34	24.88	3.70	26.99	4.09	-2.10	4.80	29.78	2.72	23.74	3.99	6.04	4.55
Degree	81	33.32	3.53	24.74	4.17	8.58	5.01	23.57	3.99	28.06	3.32	-4.49	4.62	30.20	3.02	21.75	4.77	8.45	5.73
2nd year	31	34.52	2.74	25.48	4.95	9.03	5.38	24.52	3.76	28.74	3.23	-4.23	4.39	30.53	2.68	22.33	5.25	8.20	5.82
3rd year	30	33.53	3.43	25.07	4.14	8.47	4.96	23.27	4.67	27.93	3.62	-4.67	5.59	31.03	2.61	21.73	4.84	9.30	6.33
4th year	20	31.15	3.90	23.10	2.10	8.05	4.66	22.55	2.95	27.20	2.90	-4.65	3.38	28.45	3.47	20.90	3.93	7.55	4.66

The result of the analysis of variance for the ideal professional, bureaucratic and service role conceptions of each grade across the certificate and degree students is shown in Table 4, 5, 6 respectively. Of the three role conceptions, only the effects of groups on the ideal professional score was significant indicating that degree students score significantly higher on the professional role conception than that of the certificate students, $\underline{F}(1, 210) = 8.24$, $\underline{p} < .01$. The effects of grade on the professional score was not significant showing that the length of exposure to types of training had no effect on the score. However, when the group and grade interacted, significant difference was detected, $\underline{F}(2, 210) = 7.66$ $\underline{p} < .05$. This result demonstrated that the length of exposure to training in each type of the programme affected significantly the score of the ideal professional concept in quite a different pattern.

Follow-up analysis by doing contrast among grades within groups and between groups among grades were conducted to identify the interaction pattern in scores of ideal professional role conceptions (Figure 2). The results shown in Table 7 revealed that the 2nd year students and the 3rd year students of the degree programme scored significantly higher on the role conception than the 1st study block and 3rd study block students of the certificate programme. Although the scores of the 4th year degree students were lower than the 4th study block of the certificate one, the result was not significant.

Within the certificate group, the ideal professional score dropped non-significantly in students of the 3rd study block but increased significantly in those of the 4th study block. However, no significant difference was detected between the 1st and 4th study block students. For the degree group, 4th year students

scored significantly higher than that of their 2nd and 3rd year counterparts.

Table 4
Two- way ANOVA for the Ideal Professional Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	142.15	47.38	4.73 **
Group	1	82.58	82.58	8.24 **
Grade	2	50.85	25.43	2.54
2-way Interactions	2	153.63	76.82	7.66 ***
Group Grade	2	153.63	76.82	7.66
Explained	5	295.78	59.16	5.90 ***
Residual	210	2105.44	10.03	
Total	215	2401.22	11.17	

*** p< .001 ** p< .01 * p< .05

Table 5
Two-way ANOVA for the Ideal Bureaucratic Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	34.23	11.41	.86
Group	1	33.68	33.68	2.52
Grade	2	.56	.28	.02
2-way Interactions	2	71.17	35.59	2.67
Group Grade	2	71.17	35.59	2.67
Explained	5	105.41	21.08	1.58
Residual	210	2803.69	13.35	
Total	215	2909.09	13.35	

*** p< .001 ** p< .01 * p< .05

Table 6
Two- way ANOVA for the Ideal Service Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	73.18	24.40	3.13 *
Group	1	26.94	26.94	3.45
Grade	2	40.11	20.06	2.57
2-way Interactions	2	127.51	63.75	8.17***
Group Grade	2	127.51	63.75	8.17
Explained	5	200.69	40.14	5.14***
Residual	210	1639.53	7.81	
Total	215	1840.22	8.56	

*** p< .001 ** p< .01 * p< .05

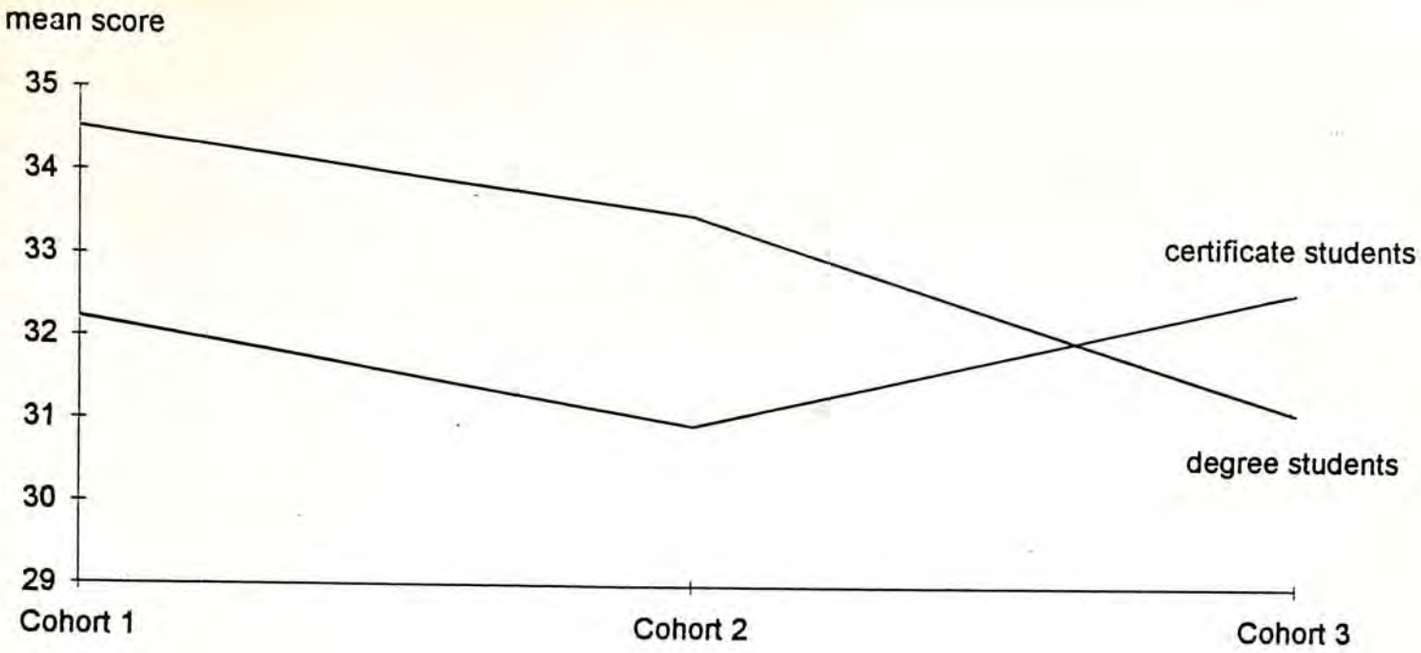

Figure 2. Interaction pattern in mean scores of ideal professional role conception

Table 7
Comparison of Ideal Professional Role Conceptions between Certificate and Degree Student with Different Grades.

		Ideal Role Conception		
Group	N	M	SD	t-value
Certificate 1st study block	40	32.23	2.94	3.35 ***
Degree 2nd year	31	34.52	2.74	
Certificate 3rd study block	52	30.98	2.94	3.52 ***
Degree 3rd year	30	33.53	3.43	
Certificate 4th study block	48	32.65	3.27	n.s.
Degree 4th year	20	31.15	3.90	
Certificate 1st study block	40	32.23	2.94	n.s.
Certificate 3rd study block	52	30.98	2.64	
Certificate 1st study block	40	32.23	2.94	n.s.
Certificate 4th study block	48	32.65	3.27	
Certificate 3st study block	52	30.98	2.64	2.68 **
Certificate 4th study block	48	32.65	3.27	
Degree 2nd year	31	34.52	2.74	n.s.
Degree 3rd year	30	33.53	3.43	
Degree 2nd year	31	34.52	2.74	3.54 ***
Degree 4th year	20	31.15	3.90	
Degree 3rd year	30	33.53	3.43	-2.49 **
Degree 4th year	20	31.15	3.90	

Note. n.s. = no significant difference
*** $p < .001$ ** $p < .01$ * $p < .05$

In terms of scores reflecting the actual situation, both groups of students perceived the actual practice of service role (certificate $\underline{M}$ = 22.65, degree $\underline{M}$ = 21.75) was to the least extent and the actual practice of professional role came next (certificate $\underline{M}$ = 26.42, degree $\underline{M}$ = 24.74). The actual bureaucratic role (certificate $\underline{M}$ = 26.65, degree $\underline{M}$ = 28.06) was practised to the greatest extent.

The results of analysis of variance for the actual professional, bureaucratic and service role conceptions of each grade across the groups of certificate and degree students are shown in Table 8, 9 and 10 respectively. Of the three role conceptions, the certificate students scored significantly higher on actual professional role conception than that of the degree students, $\underline{F}(1, 209) = 11.83$ $\underline{p} < .05$. In contrary to the ideal bureaucratic role conception, the degree students scored higher on the actual bureaucratic role conception than that of the certificate students, $\underline{F}(1, 209) = 7.52$ $\underline{p} < .05$. Main effect for grade was not found nor was group by grade interaction detected. The two groups were comparable on the actual service role conception scores.

Table 8
Two-way ANOVA for the Actual Professional Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	163.01	54.34	4.00 **
Group	1	160.80	160.80	11.83 ***
Grade	2	6.56	3.28	.24
2-way Interactions	2	72.28	36.14	2.66
Group Grade	2	72.28	36.14	2.66
Explained	5	235.29	47.06	3.46 **
Residual	209	2842.14	13.60	
Total	214	3077.42	14.38	

*** $\underline{p} < .001$ ** $\underline{p} < .01$ * $\underline{p} < .05$

Table 9
Two-way ANOVA for the Actual Bureaucratic Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	102.68	34.23	2.80 **
Group	1	92.06	92.09	7.52 **
Grade	2	6.23	3.11	.26
2-way Interactions	2	25.97	12.99	1.06
Group Grade	2	25.97	12.99	1.06
Explained	5	128.65	25.73	2.10
Residual	209	2557.32	12.24	
Total	214	2685.97	12.55	

*** p< .001 ** p< .01 * p< .05

Table 10
Two-way ANOVA for the Actual Service Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	84.87	28.29	1.65
Group	1	39.33	39.33	2.30
Grade	2	36.30	18.15	1.06
2-way Interactions	2	99.92	49.96	2.92
Group Grade	2	99.92	49.96	2.92
Explained	5	184.79	37.00	2.16
Residual	209	3581.18	17.14	
Total	214	3765.97	17.60	

*** p< .001 ** p< .01 * p< .05

Differences in Discrepancy Role Conception

To investigate the difference in the students' role discrepancy scores of each of the three conception types, two-way ANOVA with the three role discrepancy score as dependent variables and the three cohort groups and educational programmes as between groups factors were computed. The mean scores and standard deviation of the ideal/actual role discrepancy of the three role conception types are shown in Table 3. The certificate students had the greatest degree of service role discrepancy score ($\underline{M}$ = 6.78) followed by the professional role discrepancy ($\underline{M}$ = 5.50). For the degree students, the service role discrepancy score ($\underline{M}$ = 8.45) was similar to the professional one ($\underline{M}$ = 8.65). Both groups of students scored least in the bureaucratic role discrepancy, but the degree students had a higher discrepancy score (M = -4.49) than that of the certificate students ($\underline{M}$ = -2.23).

The positive discrepancy score revealed the perception that the actual practice did not meet the nurses' expectations whereas the negative bureaucratic discrepancy score suggested that the actual practice of bureaucratic role exceeded the individual's expectation for this role.

In other words, for the certificate students, the service role was practised to the lesser extent than they perceived they should be and the professional role was the next in discrepancy. The bureaucratic role was practised to the greater extent than they expected they should be. For the degree students, both the professional and service role were practised to the less extent than they perceived they should be. The bureaucratic role was practised to the greater extent than they perceived they should be.

The result of analysis of variance indicated that the degree students had a significantly greater discrepancy score than the certificate students across all three role conceptions (Table 11, 12 and 13). Main effect of grade and interaction effect between groups and grades were not detected.

Table 11
Two-way ANOVA for the Discrepancy Professional Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	513.22	171.07	8.81 ***
Group	1	474.52	474.52	24.43 ***
Grade	2	26.88	13.44	.69
2-way Interactions	2	15.48	7.74	.40
Group Grade	2	15.48	7.74	.40
Explained	5	528.71	105.74	5.44 ***
Residual	209	4059.80	19.43	
Total	214	4588.50	21.44	

*** p< .001 ** p< .01 * p< .05

Table 12
Two-way ANOVA for the Discrepancy Bureaucratic Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	245.82	81.94	3.79 **
Group	1	235.68	235.68	10.91 ***
Grade	2	3.00	1.50	.07
2-way Interactions	2	16.08	8.04	.37
Group Grade	2	16.08	8.04	.37
Explained	5	261.90	52.38	2.43 *
Residual	209	4514.65	21.60	
Total	214	4776.54	22.32	

*** p< .001 ** p< .01 * p< .05

Table 13
Two-way ANOVA for the Discrepancy Service Role Conceptions of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	264.10	88.03	3.73 **
Group	1	124.78	124.78	5.28 *
Grade	2	109.61	54.81	2.32
2-way Interactions	2	94.96	47.48	2.01
Group Grade	2	94.96	47.48	2.01
Explained	5	359.06	71.81	3.04 **
Residual	209	4935.78	23.62	
Total	214	5294.84	24.74	

*** p< .001 ** p< .01 * p< .05

Differences in Ethical Decision-making

To evaluate the difference in students' ethical decision making, two-way ANOVA with ethical decision making as dependent variable and the three cohort groups and educational programmes as between groups factors was conducted and analyzed. The mean scores and standard deviation of the ideal and actual ethical decision making are shown in Table 14.

Table 14
Means and Standard Deviations of Ideal and Actual Ethical Score between Certificate and Degree Students with Different Grades.

Group		Ethical Score			
		Ideal		Actual	
	N	M	SD	M	SD
Certificate	140	31.33	2.91	25.45	4.33
1st study block	40	30.49	2.73	23.41	3.85
3rd study block	52	31.79	2.80	26.17	4.27
4th study block	48	31.54	3.07	26.35	4.30
Degree	81	31.55	3.57	22.40	4.86
2nd year	31	31.86	2.93	21.41	4.97
3rd year	30	32.03	2.94	23.35	5.41
4th year	20	30.40	4.93	22.50	3.80

The result of analysis of variance on ideal ethical score indicated no significant difference between the certificate and degree students (Table 15).

Table 15
ANOVA for the Ideal Ethical Score of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	39.52	13.17	1.30
Group	1	4.51	4.51	.45
Grade	2	35.74	17.87	1.77
2-way Interactions	2	50.86	25.43	2.51
Group Grade	2	50.86	25.43	2.51
Explained	5	90.38	18.08	1.79
Residual	198	2002.86	10.12	
Total	203	2093.23	10.31	

*** $p < .001$ ** $p < .01$ * $p < .05$

For the actual ethical score (Table 16), main effects on groups and grades were significant revealing that the certificate students achieved a significant higher ethical score, $F(1,198) = 19.32$, $p < .05$ than that of the degree students and students among the three cohort groups were also found to have significant differences in ethical scores. Interaction between groups and grades was detected.

Post hoc contrast tests among different cohort groups were conducted to identify the interaction pattern of the actual ethical score. The results shown in Table 17 indicated that the students from the cohort group 2 and 3 scored significantly higher score than that from the cohort group 1 and no significant difference was detected between cohort group 2 and 3.

Table 16
Two-way ANOVA for the Actual Ethical Score of the Certificate and Degree Student Groups by Grades.

Source of Variance	*df*	*SS*	*MS*	*F*
Main Effects	3	678.23	226.08	11.57 ***
Group	1	377.64	377.64	19.32 ***
Grade	2	241.26	120.63	6.17 **
2-way Interactions	2	25.22	12.61	.65
Group Grade	2	25.22	12.61	.65
Explained	5	703.45	140.69	7.20 ***
Residual	198	3869.42	19.54	
Total	203	4572.88	22.53	

*** p< .001 ** p< .01 * p< .05

Table 17
Comparison of Actual Ethical Scores among Students in the Three Cohort Groups

		Actual Ethical Score		
Cohort group	N	M	SD	t-value
1	64	22.56	4.43	3.32***
2	74	25.18	4.86	
1	64	22.56	4.43	-3.24***
3	66	25.18	4.49	
2	74	25.18	4.86	n.s.
	66	25.18	4.49	

Note. n.s.. = no significant difference
*** p< .001

Differences in Perception of Ward Learning Climate

To evaluate the difference in students' perception of ward learning climate, two-way ANOVA with the three role conception types as dependent variables and the three cohort groups and educational programmes as between groups factors was performed. The results indicated no significant difference between the certificate and degree students in their perception of the learning climate variables. Main effect of grade and interaction effect between groups and grades were not detected. The mean scores and the standard deviation of the four learning climate variables are shown in Table 18.

Content analysis of the two open-ended questions: 'what do you like least about the wards' and 'what do you like least about the wards' revealed uniformity of description from both groups. Four patterns of responses which were developed in accordance with the concept of ward learning climate were uncovered (Appendix. XII). To evaluate the difference in the students' pattern of responses, chi-square test was performed and the results are shown in Table 19. Of the four patterns of responses, only response related to poor learning environment had a significant difference between the certificate and degree students, $\chi^2(1, N = 15) = 6.24, p < .05)$.

Table 18
Mean Scores and Standard Deviation of the Perception of Ward Learning Climate between Certificate and Degree Students

		Ward Learning Climate							
		Communication		Orientation		Teaching		Attitude	
Group	N	M	SD	M	SD	M	SD	M	SD
Certificate	140	34.27	4.72	11.33	2.00	17.74	3.29	38.68	6.33
1st study block	40	33.13	4.91	11.10	2.30	17.50	2.76	38.73	7.34
3rd study block	52	34.10	5.05	11.53	1.68	18.15	3.58	38.60	6.05
4th study block	48	35.40	4.00	11.31	2.08	17.51	3.38	38.71	5.81
Degree	81	35.03	6.10	11.30	2.48	17.52	3.12	38.21	5.84
2nd year	31	33.67	6.60	10.68	3.20	16.71	3.50	37.23	5.65
3rd year	30	36.83	5.60	11.73	2.00	18.33	3.16	38.87	6.67
4th year	20	34.32	5.63	11.60	1.64	17.35	2.09	38.75	4.78

Table 19

Comparison of Response Pattern on the "Best like ward" and "least like ward" between the Certificate and Degree Student.

Pattern		"Best like ward"			Least like ward"		
		frequency	%	χ^2	frequency	%	χ^2
Patient care	Certificate	79	56.43	1.3	8	5.71	.02
	Degree	52	64.20		5	6.17	
Interpersonal relationship and attitude	Certificate	30	21.43	.31	88	62.86	.04
	Degree	20	24.69		52	64.20	
Learning	Certificate	34	24.29	.12	5	3.57	6.24*
	Degree	18	22.32		10	12.35	
Ward organization	Hospital	8	5.71	.43	50	35.71	.54
	Degree	3	3.70		25	30.86	

* $p < .05$

Relationship Among Ethical Decision-making, Role Conception and Learning Climate

To determine the relationship among ethical decision making, role conception and ward learning climate, Pearson product-moment correlations were computed and analyzed. The results are shown in Table 20 and 21 respectively. For the certificate students, the ideal ethical score was found to correlate significantly with the ideal service role conception score only. The actual ethical score was found to correlate significantly with the actual professional and actual service role conception while the latter correlated more strongly with the ethical score. No correlation was detected between the ideal ethical score and any ward learning climate variables.

For the degree students, correlation was found between ideal ethical score and the ideal professional role conception and the pattern of correlation between the actual ethical score and role conception was similar to that of the certificate students. Correlation between the actual ethical score and the "communication lines approachability" variable of the ward learning climate was evident.

Table 20

Correlation between Ethical Score, Role Conception and Learning Climate of Certificate Students.

	Ideal ethical score	Actual ethical score	Actual professional	Actual bureaucratic	Actual service	Ideal professional	Ideal bureaucratic	Ideal service	Sumwardc
Ideal ethical score	1.00								
Actual ethical score	.30 **	1.00							
actual professional	-.03	.24 *	1.00						
Actual bureaucratic	.19	.06	.10	1.00					
Actual service	-.06	.32 **	.45 **	-.08	1.00				
Ideal professional	.10	.09	.23 *	.15	.11	1.00			
Ideal bureaucratic	-.16	.01	-.04	.15	.06	-.09	1.00		
Ideal service	.21 *	.08	.14	.11	.17	.34 **	-.02	1.00	
Sumwardc	.01	.20	.34 **	-.01	.23 *	.08	.14	.01	1.00
Communication	.01	.19	.31 **	-.02	.23 *	.14	.02	.00	.80 **
Orientation	.04	.09	.14	.06	.24 *	.25 *	.06	.24 *	.24 *
Teaching	-.07	.07	.19	.05	.07	.03	.05	-.09	.62 **
Attitude	.03	.17	.26 *	.19	.15	-.05	.19	-.05	.87 **

One-tailed significance * p < .01 ** p< .001

Table 21

Correlation between Ethical Score, Role Conception and Learning Climate of Degree Students.

	Ideal ethical score	Actual ethical score	Actual professional	Actual bureaucratic	Actual service	Ideal professional	Ideal bureaucratic	Ideal service	Sumwardc
Ideal ethical score	1.00								
Actual ethical score	.22	1.00							
actual professional	-.02	.33 *	1.00						
Actual bureaucratic	-.01	.15	-.04	1.00					
Actual service	-.06	.37 **	.70 **	-.154	1.00				
Ideal professional	.39 **	-.02	.08	.37 **	-.14	1.00			
Ideal bureaucratic	-.17	-.03	.22	.25	.31 *	.01	1.00		
Ideal service	.15	.19	.06	.29 *	-.05	.51 **	-.03	1.00	
Sumwardc	.02	.27	.19	.11	.18	.05	.09	.10	1.00
Communication	.10	.34 *	.13	.11	.13	.15	-.05	.16	.83 **
Orientation	-.03	.21	.15	.22	.17	.02	.09	.24	.67 **
Teaching	-.11	-.04	.08	.00	.08	.01	.06	-.02	.65 **
Attitude	.02	.20	.20	.04	.16	-.04	.18	.00	.82 **

One-tailed significance * p< .01 ** p< .001

To evaluate the joint effect of role conception and learning climate on ethical score, multiple stepwise regression analyses with ideal and actual ethical score as the criterion variables and the three role conception types as predictors were performed. The results shown in Table 22 indicated that ideal professional role conception was a significant predictor (beta = .37 , $p < .001$) for the ideal ethical score in the degree students accounting for 17% of the variance. This showed that degree students with stronger ideal professional role conception were higher in their ideal ethical decision-making. For the actual ethical score, actual service role conception was found to be the a significant predictor among others for both the certificate (beta = .37, $p < .001$) and degree students (beta = .37, $p < .001$), accounting for 10% and 14% of the variance respectively. "Communication lines approachability" (beta =.33, $p < .001$) of the learning climate variable explained an additional 9% of the variance for the actual ethical score in degree students.

For the certificate students, the ideal service role conception explained only 4% of the variance in the ideal ethical scores (beta = .20. $p < .05$). This showed that the magnitude of relationship between the former and the ideal ethical score was quite small.

Table 22
Multiple Stepwise Regression with Ethical Score as Criterion Variable and Role Conceptions, Learning Climate Variables as Predictors.

Criterion	Predictors	R	R^2	change in R^2	β
Certificate					
Ideal Ethical Score	Ideal Service	.20	.04		.20 *
Actual Ethical Score	Actual Service	.32	.10		.37 ***
Degree					
Ideal Ethical Score	Ideal Professional	.40	.17		.37 ***
Actual Ethical Score	Actual Service	.37	.14		.37 ***
	Communication Line Approachability	.47	.22	.09	.33 ***

*** $p < .001$ ** $p < .01$ * $p < .05$

To investigate the effects of discrepancy role conception on the ethical score, multiple stepwise regression analyses with ethical score as criterion variable and the three role discrepancy score as predictors were computed. For the certificate students, the discrepancy bureaucratic role conception was found to be a better predicator for (beta = -.17, $p < .01$) for the ideal ethical scores accounting for 8% of the variance (Table 23). Discrepancy professional role conception was a significant predictor for ideal ethical score (beta = .18, $p < .01$) and actual ethical score (beta = -.25, $p < .001$) accounting for 8% and 7% of variance in the degree students. The results showed that for the certificate students, higher discrepancy in bureaucratic and service role conception led to lower ideal and actual ethical decision-making. For the degree students, higher discrepancy in professional role conception was related to lower actual ethical decision-making.

Table 23
Multiple Stepwise Regression with Ethical Score as Criterion Variable and Discrepancy Role Conceptions as Predictors.

Criterion	Predictors	R	R^2	β
Certificate				
Ideal Ethical Score	Discrepancy Bureaucratic	.27	.08	-.17 **
Actual Ethical Score	Discrepancy Service	.22	.05	-.22 **
Degree				
Ideal Ethical Score	Discrepancy Professional	.28	.08	.18 **
Actual Ethical Score	Discrepancy Professional	.25	.07	-.25 *

*** $p < .001$ ** $p < .01$ * $p < .05$

In summary, the hypothesis of the relationship among the ethical score, the role conception types and learning climate was observed. Among the three role conception types, the ideal professional role conception was found to be the best predictor among others for the ideal ethical score and actual service role conception for the actual ethical score. A total of 22% of variance in students's ethical decision making was accounted by the actual service role conception and the learning climate variable, "communication lines approachability". The discrepancy bureaucratic and professional role conception was found to have a negative effect on ethical decision-making.

CHAPTER 5

DISCUSSION AND LIMITATIONS

The purpose of this study was to examine the relationships among the ethical decision making, role conception and perception of learning climate of the nursing students from the hospital-based and degree educational programmes. For the ethical decision making, each student nurse was asked to respond to six stories depicting nurses in ethical dilemma situations. To study the role conception, the three nursing role conceptions--professional, bureaucratic, and service as perceived by student nurses were adopted. The ward learning climate was differentiated into four key indicators, namely, "communication lines approachability", "patient/task orientation", "teaching" and "attitude to student" for analysis. Integrating both theoretical and empirical works from the related areas of research, five hypotheses were established and tested. As discussed in the previous session, all the five hypotheses were generally supported by the findings in the present study.

Differences in Professional Role Conception

For the ideal professional role conception, the degree students had a significantly higher score than that of the certificate students. The degree students perceived that the ideal role conceptions should be practised to a greater extent than did the certificate students. But their perception on the actual score (i.e. what was practised) was exactly the opposite of the ideal score when compared with the latter one. The degree students had a greater professional role

discrepancy than the hospital students. This was consistent with that of other studies on role conception (Corwin & Tavis, 1962; Davis, 1972; Pieta, 1976). In Corwin and Taves's study, the degree graduates had significantly higher professional role conceptions than diploma nurses and experienced more conflict between the ideal and actual role conception, resulting in greater role discrepancy upon graduation.

In analyzing the data among different stages of the programme, professional role conception fluctuated slightly but essentially unchanged for the certificate students. The lack of significant change might be due to the earlier and consistent exposure to ward reality which not only allowed them more gradual adaptation to the ward but also led to more realistic comprehension of the role of the nurse (Riffle, Lamberth, Moine & Fielding, 1985). A number of studies have shown that by the end of their first year, most students found that they were expected to be competent in their practical nursing skills and function as a "worker" rather than a student (Hughes, 1958 ; MacGuire, 1969; Wilson, 1991). This role expectation was quite distinctive to the certificate student throughout the training programme. Therefore, in order to survive the clinical practice safely, submission became a major feature of the learning process. As Fretwell (1982) and Ogier (1981) contended, students were socialized to become non-critical and obedient employees, subordinate to hospital goals and decision of the ward. Socialization, in this respect, presumably has served as a protective device to the student. It assisted the students to act "appropriately" and reduced role conflict arising from the dichotomy of being a student and a worker. As a result of this early identification with such clear role behaviour in these certificate students, the

constant role conception score as they progressed through the training was just an expected result.

A drop of ideal role conception score was noted in the 3rd study block of the certificate students but the score was not significantly different from that of the 1st study block students. Moreover, no significant difference between the 1st and 4th study block students was detected. Since the present study was a cross-sectional survey, it was difficult to explain that the drop though, non-significant, was due to the educational programme effect or the effects of extraneous sampling variables such as quality of students. It was plausible that the students of the 3rd study block possessed a lower ideal professional role concept at the onset of the programme.

Compared to the certificate students, the degree students had a more drastic change in the developmental pattern of role conceptions and role deprivation. The ideal professional role conception decreased significantly upon entry to the 3rd year and dropped even further in the 4th year of the education programme. This result was different from Davis (1972) and Kramers' (1974) studies in which the professional role conception increased from entrance to graduation and dropped significantly only within the first six months after graduation. Kramer postulated that the marked drop of professionalism was the result of "reality shock".

Kramer (1968) asserted that the nursing faculty were successful in professionally socializing the students into acquiring an "ideal" conception of nursing rather than a "reality" role conception. Students learned what the profession believed should be the practice (Abrahamson, 1967; Clausen et al.,

1968). But once they entered into the working world, they found many of these role values were not functional resulting in role conflict. Based on this assertion, the decreasing professional orientation as the degree students progressed through the programme might indicate that Hong Kong students experienced the reality shock earlier than their American counterparts. Such "shocking" effect occurred early in their exposure to ward reality and persisted through their clinical placement. The different findings could be accounted by the different arrangement of clinical placement between the Hong Kong and American degree programme which usually has a hospital as a home base for the students' early clinical attachment.

Unlike the former students who were affiliated with the same hospital throughout their training, the degree students obtained their clinical experience from more than one hospital throughout the programme. Pattern of nursing care often varied with different hospital and constant adjustment was required within a short period of time. Moreover, short duration of ward allocation which varied from 2 to 4 weeks further cultivated a sense of being an "outsider" to various wards. Being an outsider and unfamiliar to the ward, the degree students were more likely to relinquish the professional value but would abide to the bureaucratic rules and regulation in order to gain acceptance to the system. In fact, the feeling of being an outsider was repeatedly mentioned in the informal follow-up interviews with several degree students. The frustration of constant readjustment to settings in different wards and hospitals might explain the persistent effect of reality shock.

Differences in Bureaucratic Role Conception

While there was no significant differences in the ideal bureaucratic role conception between students in the two types of educational programme, there was significantly higher actual and discrepancy bureaucratic role conception in the degree students. The negative discrepancy score indicated that the bureaucratic role was practised to the greater extent than they expected they should be. This finding lend support to the above assertion that degree students experienced reality shock early in their clinical experience. Kramer (1974) found that degree graduates had a significant increase in bureaucratic role conception within the first three to six months after exposure to the hospital work situation. Compared to the hospital-based students, the degree students were more pressurised to adhere to the bureaucratic system owing to their position as an outsider to the ward and lack of familiarity with the ward. Any breaking of rules might be perceived as not being respectful to the visiting hospital and thus students were reminded of doing the "local ways".

In fact, the analysis of students' responses to items comprising the bureaucratic role further confirmed the above interpretation. Of the eight items, item #18 which addressed belief about following all hospital rules even though they were not fully agree with and item #22 which addressed belief about the need to accomplish all routine work in order to be considered as useful had the highest agreed score (75%). Item #4B which related to the need to carry out hospital routine for promotion and item #14 which addressed the need to finish routine work within a set time had the second highest score (65%). These responses seem to confirm the assertion that the hospital routine were given prime important

in reality by the degree students.

The significantly lower discrepancy role score in the certificate students concurred with the findings of Pieta's (1976) study. This result could be accounted by the early organizational socialization occurred in these students. As the certificate students were left to work independently in much of the time, adhering to the organization rules and regulation and doing work according to norms were considered as the most efficient and safest ways of performing a task for them. In fact, they have been socialized to subordinate to hospital goals and needs and accepted it as a reality to their learning early in the training programme.

Differences in Service Role Conception

The result indicated no significant differences in the ideal and actual service role conception between the two groups of students. However, for the discrepancy role conception, the degree students had a significantly higher scores than the certificate students. Being affiliated with the same hospital throughout the training and being part of the workforce to the hospital, the certificate students were more likely to be involved in decisions about patient care than their degree counterparts. This might lead to less variance in their perception of the actual practice.

For the degree students, the frequent rotations of different clinical sites to different hospital throughout the programme required them to make constant adjustment to new situations. As Moran and Volkwein (1992) describes, organizational climate is a relatively enduring characteristic of an organization

which differentiate it from other organizations. Prevalent norms, values and attitudes which emerge through interaction among member exist within each organization. Since it influences and shapes behaviour, it could be served as a basis for interpreting the situation. Based on this concept, one may argue that the frequent changes of ward environment from one hospital to another may further incapacitate the degree students to get acquainted with different ward practices in patient care resulting in more variance in their perception of actual practice of patient care.

Differences in Ethical Decision-making

Degree students in this study were shown to have lower actual ethical score than the certificate students. When compared the score among different level of grades, the higher ethical scores were found among the cohort 3 students. This suggests that degree students and students of junior grade have a more pessimistic view about the ethical practice in actual setting than the certificate and their senior counterparts.

It has been suggested nurses with more clinical experiences and previous experience in dealing with ethical dilemma situation can facilitate ethical decision making (Crisham, 1981; Cassell & Redman, 1989). Compared to the degree students who practised with close supervision by faculty in hospitals for two to three days a week, the certificate students had far greater exposures to different dilemma situations and ethical issues. With more clinical and previous experiences about real-life nursing dilemmas, individual students might develop more realistic perception of possible consequences of an action. Besides, working

independently most of the time in wards of the same hospital, the certificate students might be in a better position to manipulate the system than the degree students in implementing ethical decision-making. This same argument could also explain why the senior students have a higher ethical score than their junior fellow students.

As argued by Cox (1985/1986) and Erlen (1991), perceived powerlessness was negatively related to ethical decision. It was possible that the degree students were being considered as an outsider to the hospital. Besides being restricted to types of nursing care they could perform, they were also required to adhere closely to rules and regulations of the hospital in order to gain acceptance to the system. Such restriction could further cultivate a sense of powerlessness in these students to exercise independent judgements in the ward learning environment.

Moreover, the result of the regression analysis of professional role discrepancy score on ethical decision-making score as demonstrated in the present study may also have some contribution to this finding. As argued by Shead (1991), role conflict results in stress which may lead to negative job attitude and a loss of concern for clients. To resolve the conflict, individuals may choose to restructure the situation, reject responsibilities for decision or establish his own priority of values. The finding of the lower ethical decision-making score and higher professional role discrepancy score seems to indicate that the degree students have possibly surrendered the "school-bred" values of patient-centred decision making in favour of the more expedient bureaucratic oriented decision about patient care.

Differences in Perception of Ward Learning Climate

The finding of no significant difference between the two groups regarding the perceived ward learning climate was unexpected. It was expected that the degree students would rate "communication line approachability" higher and "teaching" and "learning" lower than the certificate students due to the emphasis of inquiry attitude fostered in the degree programme and the presumably influential power of ward sister to the certificate students in the ward. The result could be explained by the lack of expectation on considering the ward as a learning climate in the certificate students. Being considered as part of the work force, they have identified themselves as a worker rather than a learner, thus, reducing the effect of learning. Yet, for the degree students who were coming as an outsider to the ward, whether the ward sister would welcome them as a learner to the ward would very much determine the learning opportunities available to them. As discussed in the literature review, the ward sister was perceived by student nurses as the most influential person in setting a ward climate conducive to learning (Orton, 1981; Ogier, 1981; Fretwell, 1982; Smith, 1988; French, 1989). Her attitude and relationship to the student affected student learning directly and the way she managed the nursing team influenced their learning indirectly.

The uniformity of student descriptions about the "most like ward" and "least like ward" confirmed the existence of ward climate as described by Orton (1981). Of the four patterns of responses, the degree students had a significantly higher response rate on the pattern related to poor learning environment. It was plausible that the degree students was more sensitive to an environment which was

not conducive to learning. Due to the already limited clinical exposure, any factors that might jeopardize their learning would be considered as undesirable.

The results were also consistent with the findings of studies on different aspirations of nurses prepared from different educational programmes (Langston, 1990; Pardue, 1987; Stephenson,1984). Responses such as the dislike of performing activities without knowing the reason and not being trusted and respected by the ward sister further reflected that the degree students were more aspired to the professional aspects of practice. Different from the supernumerary status of their degree counterparts, the certificate students have learned to cope with the role conflict as discussed in the preceding section, by mastering the rhetoric of the education system and the practicalities of the service (Melia, 1987). In order to survive the clinical practice, they were found to adapt very quickly to the reality of the ward (Wyatt, 1978). As Melia (1981) described, students were adept at fitting with the expectations of different staff members. They also viewed nursing as one of "getting on and getting through". In fact, this constant adaptation to fit the ward reality became part of the learning process and the development of a higher tolerance for the negative aspects of the learning environment was only a natural consequence for these certificate students.

Relationship among Ethical Decision-making, Role Conception and Learning climate

For the certificate students, the service role conception was a significant predictor for both the ideal and actual ethical decision making. However, for the degree students, the ideal professional role conception was a better predictor for

the ideal ethical decision making, while the actual service role conception and the learning climate variable, "communication lines approachability" for the actual ethical decision making.

The finding of the positive relationship between the ideal professional role conception and ideal ethical decision making in this study supported the previous research by Ketefian (1985). Moreover, the result further confirmed that socialization process occurs differently according to type of educational programme. As discussed previosuly, the certificate students are socialized to hold a more traditional view of nursing with more emphasis on direct patient care. Whereas the degree students are socialized to value independent judgement, to function autonomously and to commit to uphold the ethical standards of their profession. However, the result of the present study showed that this ideal conception of the professional only contributed to one's ideal ethical decision. Once it came to the realistic situation, it was the service role orientation that gave a better prediction of an individual's ethical decision making. In fact, such relationship was consistent with Corwin's (1960) concept of service role orientation which emphasizes primary loyalty to patients and humanitarian nursing care. Therefore, it was desirable to encourage both the degree and certificate students to maintain the service role conception of which they aspire to.

In addition to demonstrating the relative predictive power of role conception, the present study went further to show how the students' perception of the ward learning climate contributed to the ethical decision-making. Of the four learning climate variables, only the "communication lines approachability" component was found to predict the actual ethical decision and such relationship was only found

in the degree students. It was plausible that the communication component of the learning climate was perceived as more important by the degree students and it was contingent upon their freedom to make ethical decision making. The survey questions related to this climatic variable mostly reflected the student's perception of how they were treated as an autonomous being who were free to approach the communication lines in the wards, for example, positive response to students' questions, encouraging to ask question, free to clarify orders from doctors and free to make suggestion about a patient.

The result further confirmed the findings of deJong's (1984/1985) study which indicated that the perception of autonomy in work environment was positively related to ethical judgment. As discussed in the preceding section, certificate and degree programmes do vary in conceptual and theoretical approaches to nursing care. Degree students who have been socialised to place greater value on professional autonomy would be more sensitive to this aspects in the ward learning climate as compared to the certificate students who have socialised to be more concerned with the technical aspects of nursing care and adherence to bureaucratic rules.

The result was also consistent with the finding of present study on the relationship between the role discrepancy and ethical decision making. The stepwise regression showed that the actual decision making was found to be negatively related to service role discrepancy in certificate students and professional role discrepancy in the degree students. In other words, the greater the service role discrepancy experienced by the certificate students, the lower the ethical score. For the degree students, the greater the professional role

discrepancy, the more adverse effect on the ethical decision making.

Limitations

Some original meaning of the questionnaire might be changed due to translation and cultural differences in interpreting the meaning of the situations. This might affect the validity and reliability of the questionnaire. Besides, since the study was limited to one hospital-authority hospital for the hospital training programme and one degree nursing programme in Hong Kong, the findings of this study cannot be generalized to all hospital-based nor degree students in Hong Kong.

The extent of familiarity with hypothetical dilemmas used in this study might also influence the consideration of the dilemma, especially for the first year nursing student, they might have difficulties to comprehend the complexity of the situation. Moreover, the predetermined, closed-ended questions and relatively simple responses to relatively complex dilemma situations might not represent the complex nature of the decision. Many variables such as the organizational context, the perceived threats and constraints in the work situation which might influence nurses' actual decisions were not depicted in the JAND scale. It was reminded that the JAND scale was reliable only in response to what subjects thought the nurse in the dilemmas was likely to do and therefore, the respondents' own actions were not inferred. Lastly, as discussed in the literature review, correspondence between a person's responses to hypothetical situations versus the actual behaviour in real-life situation was questionable.

CHAPTER 6

CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

Conclusion

To conclude, results of the present study were consistent with many studies which demonstrate the existence of role conflict once the new graduate enters the world of hospital nursing (Corwin, 1960, 1961b; Kramer, 1974; Pieta, 1976; Green, 1988). Findings of the present study supported the previous literature which discussed the relationship between the nursing role conception and ethical decision making. The impact of the ward learning environment on the development of students' nursing role conception and dilemma resolution ability was also demonstrated. Perceived autonomy in the ward environment, particularly the necessity of communication lines approachability had an positive impact on ethical decision making for the degree students.

This study was also consistent with the assertion that some degree of role conflict is inevitable in complex organizations (Kahn, 1974). The interest of bureaucratic organization in standardized routine practice is often in conflict with the ideal practice of professional nursing. The ward environment where most nursing practice take place deter nurses from assuming responsibilities for independent thinking. Compared to the certificate students, the practice setting seem to exert far greater impact on the perception of degree students' role conceptions and ethical decision-making.

Implications and Recommendations

Degree and hospital-based certificate students differed significantly from each other in their perceptions of the ideal and actual professional role and actual bureaucratic role conception. Besides, degree students who were found to have the greatest role discrepancies for all the three role conceptions also had significantly lower score in ethical decision-making when compared with the certificate students. As discussed by Kramer (1974), discrepancies can lead to frustration and conflict. Many nurses who experience high frustration when come to terms with the reality in work environment may leave hospital practice. With the trend in nursing towards educating nurse in a degree level, this finding has implications for nursing education programme. Failure to minimize the role discrepancies of degree students could result in more role conflict and subsequent job dissatisfaction, low morale and high turnover rate.

Therefore, it is recommended that degree nursing education programme should include course that would provide students with more realistic experience in a hospital setting. The course should allow more student participation in all dimensions of a reality shock situation whereby students may choose feasible alternatives.

Since there was a significant relationship between the service role conception and actual ethical decision making, nursing education should cultivate this traditional focus of nursing and emphasize the importance of direct nursing care to patients. The significant difference between the certificate and degree students in the ethical score implicates a need for the degree students to learn more about ethical dilemma through more exposure to direct patient care. The clinical

practice which constitute the reality of nursing practice should structure in ways that will allow students to have ample opportunities to practice decision making in relation to patient care. Supports and supervision should also be made available to both the certificate and degree students through a preceptorship programme.

A ward learning climate which values students' inquiry spirit should be encouraged as it is conducive to ethical decision-making. The health team in the ward and the ward sister in particular should make students feel approachable and free to make inquiry about the patient care.

Suggestions for Further Research

This study was limited in that it was quantitative in nature. A qualitative approach which include interviews to ascertain why nurses perceived that they are not engaging in what they believe is ideal nursing practice may provide a better understanding of the cause of role discrepancy. Adaptive strategies could then be developed to help nurses to cope with the disparity.

Further studies which include interviews with open-ended questions to explore the reasons behind the decisions may provide a better understanding of the complex nature of decisions in dilemma situations. A qualitative approach to identify and describe ethical dilemmas that nurses in Hong Kong actually encounter everyday may help to develop an instruments with hypothetical situations more representative of the local situation.

A longitudinal study adopting the similar research methodology and study design should be conducted for the sample population over a 6 months and one

year period after their graduation. This follow-up study might allow one to gain some insights into the possible subsequent changes in nurses' role conceptions and their ethical decision-making ability.

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APPENDIX: I

CODE FOR NURSES

1. The nurses provides services with respect for human dignity and the uniqueness of the Client; unrestricted by considerations of the social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgements and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in meeting consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participation in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's efforts to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public

(American Nurses' Association, 1985, p.1)

APPENDIX: II

LETTER OF REQUEST FOR APPROVAL

Hilary Ha-Ping Yung
Department of Nursing
The Chinese University of Hong Kong

September, 1993

Dear Ms

I am writing to ask for help in a study which is conducted as a master project at the Faculty of Education, Chinese University of Hong Kong. As I have always been intrigued by the hospital-based nursing training, I would like to carry out a study on the effect of nursing education on student nurses' opinion about nursing and judgments about nursing decisions. the study will attempt to answer the question as follows:

1. How is the opinion about nursing of the hospital-based training students different from the degree nursing students?
2. How is the decision-making ability of the hospital-based training students different from the degree nursing students?
3. What are the relationship among the decision-making, opinion about nursing and perception of learning climate of the nursing students from the two nursing educational programmes?

The project is an exploratory study and the population will include student nurses of the first and final year from the hospital-based training and tertiary education. I would appreciate if would kindly let me use her students of as my sample population. The name of the school will be kept confidential.

The data-collection tool consists of three sets of questionnaire and it will take about one hour to complete. I would be present in person to explain the study to the students during their study block in November and December at your kind permission. Enclosed is a sample of the questionnaire and if you would like additional information of the study, I would be delighted if you contact me at 609-7474, Fax No. 603-5520, Department of Nursing.

I would see this as a good opportunity to stimulate students' interest in the area of research which is considered as an important component in nursing education. Results of the study could also provide some insights on how nursing education affects nurses' perception about nursing and their decision-making ability. It is hoped that such information could be useful for nurse educators and administrators as they have much opportunities to prepare nurses for making sound nursing judgments. results of the study will be available for your and the students' interest.

Since data-collection will take some time and the completion date of my project is April, 1994, I would be grateful for an early reply if possible.

Thank you very much for your time and consideration.

Yours sincerely,

Hilary Ha-Ping Yung (Lecturer)

APPENDIX: III

QUESTIONNAIRE INSTRUCTIONS

(1) The purposes of the three sets of questionnaire are to find out:
a. your opinions about the nursing profession.
b. your responses to dilemma situations.
c. your opinion about the hospital ward as a setting for student learning.

(2) Please put a ' ' in the relevant column which most accurately represent your view. There are no right or wrong answers.

(3) For columns which vary from 'strongly agree', 'agree', 'undecided', 'disagree', 'strongly disagree', please indicate the degree you agree or disagree with the statement by putting a ' ' to the appropriate column.

Strongly Agree	indicates that you agree with the statement with almost no exceptions.
Agree	indicates that you agree with the statement with some exceptions.
Undecided	indicates that you could either 'agree' or 'disagree' with about an equal number of exceptions in either case.
Disagree	indicates that you disagree with the statement with some exceptions.
Strongly Disagree	indicates that you disagree with the statement with almost no exceptions.

(4) Please avoid using the 'undecided' column unless it is impossible for you to agree or disagree.

(5) You can be rest assured that this questionnaire will not make any reference to your identity, your hospital name or wards.

Complete confidentiality is guaranteed.

Thank you for your kind consideration!

Hilary H Yung
Department of Nursing
Chinese University of Hong Kong

APPENDIX: IV

LETTER TO STUDENTS

Hilary Ha-Ping Yung
Department of Nursing
The Chinese University of Hong Kong

December, 1993

Dear students,

I am writing to ask for your help in my master project at the Faculty of Education, Chinese University of Hong Kong. Its purpose is to study the effect of nursing education on student nurses' opinion about nursing and judgments about nursing decisions.

Needless to say, your willingness to participate will be very much appreciated and I am sure you will find this a stimulating experience in the area of research.

You will be requested to complete a set of questionnaire which is not a test and therefore has no right or wrong answers. Your name will not be required and thus it will be impossible to reveal your identity or your individual responses.

I have already been granted permission from the Head of the Department and the Ethics Committee of the to come in a designated time between December and January to explain to you in person concerning the project. You will be more than welcome to clarify with me any query you have before you decide if you want to participate in the study or not.

The completion date of my study is June 1994 and if you are interested in the result of the findings, I would be delighted if you contact me at 609-7474, Department of Nursing after June 1994.

Thank you very much for your participation.

Yours sincerely

Hilary Ha-Ping Yung (Lecturer)

APPENDIX: V

CONSENT FORM

I (the participant) have been informed of the study and any questions I have asked have been answered to my satisfaction.

I agree to participate in this activity, realising that I may be withdraw at any time.

_____ _____

(Participant) (Date)

_____ _____

(Investigator) (Date)

APPENDIX VI

DEMOGRAPHIC DATA

Sex Male_____ Female_____

Age
Below 20 ____
20 - 24 ____
25 - 29 ____
30 - 34 ____
35 - 39 ____
over 39 ____

Stage of training
____ 1st year
____ 2nd year
____ 3rd year
____ 4th year

____ Hospital-based programme
____ Degree programme

Previous work experience as an enroled nurse. Yes ____ No ____
Previous experience in nursing before the training. Yes ____ No _____

If Yes, length is ____

APPENDIX VII

NURSING ROLE CONCEPTION INVENTORY

Professional role conception

1. A registered nurse tries to put her standards and ideals about good nursing into practice even if they are in conflict with the hospital rules and procedures.

2. Registered nurse attend conferences outside of hospital to learn about new techniques and to increase their knowledge of various topics.

7. Some registered nurses believe that they can manage the job well without a lot of formal education, such as a B.S., M.S. or M.A. university degree.

8. Registered nurses subscribe to and read professional journals in order to keep abreast of new techniques and knowledge.

12. In considering a registered nurse for promotion, one of the most important factor considered by the nursing director is her knowledge of, ability to use judgment about the nursing procedures.

13. Some registered nurses try to up hold what they think are the standard of their profession even if their colleagues or nursing officers don't seem to like it.

19. Registered nurses attend inservice meetings at the hospital even when they are not required to attend.

20. Registered nurses are active members of their professional nursing association.

Bureaucratic role conception

3. A nursing officer insists that all procedures be performed as described in the Procedure Manual.

4. A registered nurse, although she performs excellent nursing care, is notbeing considered for promotion because she does not carry out hospital routines as established.

#11. A registered nurse often reports to duty 15 minutes later than the designated time due to the bus schedule. Because she is always late, she is not considered for promotion.

#14. A registered nurse explains to a patient who demands a lot of her time that she has to go because she does not want to fall behind her work schedule.

#15. When evaluating registered nurses for promotion, nursing directors consider the nurse's length of working experience to be important.

#18. A registered nurse follows all hospital routines even though she disagrees with some of them.

#21. The policies at a hospital state that any violation of hospital regulations must be reported. A registered nurse observed her colleague violating a hospital regulation and reported the incident to the nursing officer.

#22. Regulations at a hospital state that all patients must have their baths and treatments complete their assignment at this time are considered valued employees.

Service role conception

#5. A registered nurse modifies the hospital routines and procedures to meet the needs of the patients.

#6. A registered nurse refuses to do anything which she believes might jeopardize the welfare of her patients regardless of who tells her to do it.

#9. When evaluating registered nurses for promotion, the nursing director should consider nurses' ability to plan nursing care appropriate to the patient's needs to be most important.

#10. Registered nurses are respected by their peers for taking time to talk with patients in order to allay patient's anxieties and promote recovery.

#16. Registered nurses spend majority of their time administering direct care to patients.

#17. A patient has difficulty sleeping during the night so the registered nurse allows him to sleep in the morning even though according to ward routine, patients should have been awakened at 7 am.

#23. While distributing the meal to patients, a registered nurse noticed a patient crying. The nurse got another nurse to distribute the meal and went to talk to the patient.

APPENDIX VIII (A)

OPINION ABOUT NURSING

This section consists of a list of twenty three situations in which a nurse might find herself. You are asked to indicate both:

(A) the extent to which you think the situation should be the ideal for nursing.

(B) the extent to which you think the situation actually exists in the hospital.

Notice that for each situation, both (A) and (B) statements are required to answer.

Consider the statements of what should be the case and what is actually the case separately; try not to let your answer to (A) statement influence your answer to the (B) statement.

Please indicate your opinion and there is no right or wrong answer.

For example:

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
1. A registered nurse consider the physical and psycho-social needs of the patient in planning nursing care.					
A. This is the way you think nurses should do.	✓				
B. This is the way you think nurses actually do.				✓	

If you agree that the nurse should consider the patient's physical and psycho-social needs in planning nursing care, without exception, then check the "Strongly Agree" column for statement A.

If you disagree, with some exception that nurses do actually consider the patient's physical and psycho-social needs in planning nursing care, then check "Disagree" for statement B.

Please be sure to put a ' ' after both statement A and B.

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
1. A registered nurse tries to put her standards and ideals about good nursing into practice even if they are in conflict with the hospital rules and procedures.					
A. Do you think this is what registered nurses <u>should</u> do?					
B. Do you think this is what registered nurses <u>actually</u> do when the occasion arises?					
2. Registered nurses attend conferences outside of hospital to learn about new techniques and to increase their knowledge of various topics.					
A. Do you think this is what registered nurses <u>should</u> do?					
B. Do you think this is what registered nurses <u>actually do</u>?					
3. A nursing officer insists that all procedures be performed as described in the Procedure Manual.					
A. Do you think this is what nursing officers <u>should</u> do?					
B. Do you think this is what nursing officers <u>actually</u> do?					
4. A registered nurse, although she performs excellent nursing care, is not being considered for promotion because she does not carry out hospital routines as established.					
A. Do you think this is the way it <u>should</u> be?					
B. Do you think this is the way it <u>actually</u> is?					
5. A registered nurse modifies the hospital routines and procedures to meet the needs of the patients.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
6. A registered nurse refuses to do anything which she believes might jeopardize the welfare of her patients regardless of who tells her to do it.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
7. Some registered nurses believe that they can manage the job well without a lot of formal education, such as a B.S., M.S. or M.A. university degree.					
A. Do you think this is what nurses <u>should</u> believe?					
B. Do you think this is what nurses <u>actually</u> believe?					
8. Registered nurses subscribe to and read professional journals in order to keep abreast of new techniques and knowledge.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
9. When evaluating registered nurses for promotion, the nursing director should consider nurses' ability to plan nursing care appropriate to the patient's needs to be most important.					
A. Do you think this is what <u>should</u> be considered important?					
B. Do you think this is what <u>actually is</u> considered important?					
10. Registered nurses are respected by their peers for taking time to talk with patients in order to allay patient's anxieties and promote recovery.					
A. Do you think this is the way it <u>should</u> be?					
B. Do you think this is the way it <u>actually is</u>?					
11. A registered nurse often reports to duty 15 minutes later than the designated time due to the bus schedule. Because she is always late, she is not considered for promotion.					
A. Do you think this is what <u>should be done</u>?					
B. Do you think this is what <u>actually is</u> done?					
12. In considering a registered nurse for promotion, one of the most important factor considered by the nursing director is her knowledge of, ability to use and judgment about the nursing procedures.					
A. Do you think this is what nursing director <u>should</u> considered as important?					
B. Do you think this is what nursing director <u>actually do</u> considered as important?					

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
13. Some registered nurses try to up hold what they think are the standard of their profession even if their colleages or nursing officers don't seem to like it?					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do when the occasion arises?					
14. A registered nurse explains to a patient who demands a lot of her time that she has to go because she does not want to fall behind her work schedule.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
15. When evaluating registered nurses for promotion, nursing directors consider the nurse's length of working experience to be important.					
A. Do you think this is what <u>should</u> be considered important?					
B. Do you think this is what <u>actually is</u> considered important?					
16. Registered nurses spend majority of their time adminsistering direct care to patients.					
A. Do you think this is what nurses <u>should</u> do?					
B. do you think this is what nurses <u>actually</u> do?					
17. A patient has difficulty sleeping during the night so the registered nurse allows him to sleep in the morning even though according to ward routine, patients should have been awakened at 7 am.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
18. A registered nurse follows all hospital routines even though she disagrees with some of them.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
19. Registered nurses attend inservice meetings at the hospital even when they are not required to attend.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
20. Registered nurses are active members of their professional nursing associations.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
21. The policies at a hospital state that any violation of hospital regulations must be reported. A registered nurse observed her colleague violating a hospital regulation and reported the incident to the nursing officer.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					
22. Regulations at a hospital state that all patients must have their baths and treatments completed by 10 am. Registered nurses who complete their assignment at this time are considered valued employees.					
A. Do you think this is the way it <u>should</u> be?					
B. Do you think this is the way is <u>actually</u> is?					
23. While distributing the meal to patients, a registered nurse noticed a patient crying. The nurse got another nurse to distribute the meal and went to talk to the patient.					
A. Do you think this is what nurses <u>should</u> do?					
B. Do you think this is what nurses <u>actually</u> do?					

APPENDIX VIII (B)

性別　　男___　女___

年歲
___ 15 - 19
___ 20 - 24
___ 25 - 29
___ 30 - 34
___ 35 - 39
___ 40 - 44
___ 45 - 49
___ 50 - 54
___ 55 - 59
___ 其他

年級
___ 1 年級　　課程 _____ 醫院制度
___ 2 年級　　課程 _____ 學院制度
___ 3 年級
___ 4 年級

在入讀此護理課程前,你有否讀過登記護士課程? 有____ 無____
在入讀此護理課程前,你有否護理工作經驗? 有____ 無____
若有,年期爲_____

你對護理的意見

導言

以下有二十三個假設的程況或許在你工作時曾遇上,請在
(A)項,表出你認爲理想中的護士行業所應有的
(B)項,表出你認爲在實際工作環境中所發到

請注意在每問題都有一個(A)項及一個(B)項,兩者需作答,請把每一項個別考慮,換句話說,盡量不給(A)項的答案影響(B)項,或(B)項的答案影響(甲)項.
請隨意表示你的意見,這些問題是沒有「對」或「錯」的答案呢.

對問題的贊成及不贊成是作一個程度上的計算,請在適當的位置上加上一個「✓」

「強烈贊成」表示你差不多在所有時候都贊成
「贊成」表示你大多數時候會贊成
「不能決定」表示一半時候你會贊成,一半時候你會反對
「反對」表示你大多數時候會反對,除了某些小數時候
「強烈反對」表示你差不多在所有時候都反對

例:

強烈贊成	贊成	不能決定	反對	強烈反對
✓			✓	

一註冊護士在計劃護理,會考慮到病人的身心靈需要.

A. 你認爲護士應該如此做
B. 註冊護士在實際情況中是如此做

假如差不多所有時候,你認爲護士應該考慮病人的身心靈需要則在A項中,「強烈贊成」的一項中加上一「✓」,又假如貴醫院的護士在大多數時候反對,但小數時候贊成在計劃護理時,考慮到病人的身心靈需要則在B項中「反對」的一項中加上「✓」.

	强烈贊成	贊成	不能決定	反對	强烈反對
1. 一註冊護士試圖實現她理想中的護理標準，這雖然是與醫院的條例及程序有所衝突的。					
A.你認為這是註冊士應該做的。					
B.你認為這是註冊護士在實際情況做的。					
2. 一註冊護士參加院外舉辦的會議講座以學習新的護理技術及增進其知識領域。					
A.你認為這是註冊護士應該做的					
B.你認為這註冊護士，實際情況中做的。					
3. 一護理部門主任，堅持所有程序均需依據程序手冊所指示而執行。					
A.你認為這是理部門主任應該做的。					
B.你認為這是護理部門主任，在實際情況中做的。					
4. 一註冊護士，工作超卓，卻因不執行醫院所訂立的常規而不被考慮在升職之列。					
A.你認為這是應該的。					
B.你認為這在實際情況中是發生的。					
5. 一註冊護士，就著病人的需要而修改病室常規或日常工作程序。					
A.你認為這是註冊護士應該做的。					
B.你認為這是註冊護士在實際情況中做的。					
6. 一註冊護士，無論是誰吩咐她的，也不會去做任何會危害病人利益的事情。					
A.你認為這是註冊護士應該做的。					
B.你認為這是註冊護士在實際情況中做的。					
7.有些註冊護士相信不需要正統教育，如學士，碩士的課程，也能應付自如。					
A.你認為這是註冊護士應該有的想法。					
B.你認為這是註冊護士在實際環境中的想法。					
8. 一註冊護士訂購及閱讀專業雜誌，以便增進認識日新月異的知識及技能。					
A.你認為這是註冊護士應該做的。					
B.你認為這註冊護士在實際情況中做的。					
9. 當護士長考慮晉升一註冊護士時。其中最重要考慮因素之一，是護士能否看重病人的需要而給予適當的護理。					
A.你認為這是護士長應該重視的。					
B.你認為這是護士長實際重視的。					
10.一註冊護士被同僚尊重，是因為她願意用時間與病人傾談，以減輕病人憂慮，促進復元。					
A.你認為這註冊護士所做的，是應該被尊重。					
B.你認為這註冊護士所做的在實際環境中是被尊重的。					
11.一註冊護士，因為巴士班次的影響，而致上班經常遲到十五分鐘。由於她經常遲到，便不被考慮在升職之列。					
A.你認為這是應該的。					
B.你認為在這實際環境中，是發生的。					

強烈贊成	贊成	不能決定	反對	強烈反對

12.護士長考慮晉升一註冊護士時，其中最重要因素之一，是她對護理步驟的知識，使用能力及判斷力。
A.你認爲這是護士長應該重視的。
B.你認爲在實際情況中，這是護士長看爲重要的。

13.有些註冊護士試圖實行她認爲的專業標準，這雖然是他的同僚或上司所不喜歡的。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊 護士在實際情況中做的。

14.一註冊護士。告訴一病人，她不能再幫他因他已花了她很多時間，不然；她便不能依時完成她的工作。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊護士在實際情況中做的。

15.當護士長考慮晉升一註冊護士時，其任職期的長短，是受考慮最重要因素之一。
A.你認爲這護士長的考慮是應該被視爲重要的。
B.你認爲這考慮在實際環境中是被視爲重要的。

16.註冊護士的工作，大部份時間用在病人的臨臨床護理上
A.你認爲這是註冊護士應該做的。
B.你認爲實際環境中，這是註冊護士所做的。

17.根據病室常規，所有病人須於早上七時起床，若一病人整夜不能入睡，註冊護士容許他早上仍睡於床上。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊護士實際如此做的。

18.一註冊護士，切實執行所有醫院規例，雖然其中有部份是她不同意的。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊士實際做的。

19.一註冊護士參加院內舉辦的進修課程，醫院雖然沒有要求她如此做。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊護士實際做的。

20.醫院中的註冊護士，都是護士團體的活躍分子。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊護士實際做的。

21.醫院規定任何有觸犯醫院規例的行爲，均需報告。一註冊護士目睹一同僚觸犯了一醫院規例或政策，便將此事報告上司。
A.你認爲這是註冊護士應該做的。
B你認爲這是註冊護士實際會做的。

22.註冊護士能在指定時間的完成一般常規，例如派藥，及換症，是一位對醫院最有用的僱員。
A.你認爲在護理行業中這想法是應該的。
B.你認爲在實際工作環境中，是有如此想法的。

23.在病房派餐時，一註冊護士覺察到一病人在哭泣。於是她要求其同僚代替她派餐的工作，而自己則與病人傾談，明白其需要。
A.你認爲這是註冊護士應該做的。
B.你認爲這是註冊護士實際會做的。

APPENDIX IX (A)

JUDGMENTS ABOUT NURSING DECISIONS

You will find six stories here where a nurse finds herself in a dilemma as to what to do. Various courses of action that a nurse might take are listed following each story; you will be asked to respond to each course of action.

There are times when a nurse may believe and think that s/he should, from a professional point of view, act in a certain manner, but because of various rules and other limiting factors that exist in an organization s/he may not always be able to act according to her/his belief. Recognizing this added dimension of conflict you are asked to respond to each action in two ways. First, respond in terms of its being professionally an ideal choice that a nurse might follow if there were no constraining factors present (Column A). Second, respond in terms of its being a realistic choice that a nurse is most likely to follow, considering possible constraints that may be present (Column B).

Different nurses will have different views on these matters, and it is your view that is sought for each of these stories, and for each of the nursing actions in Column A and in Column B. You need not feel that your answers have to be different for Column A than they are for Column B. They may be similar, or they may be different; it is your honest judgment in each instance that we seek.

Please note that the nursing actions listed are not mutually exclusive, in that taking one particular action does not mean that the nurse may not take any of the other actions listed.

A suggestion only: It may be simpler if you went through all the actions and answer Column A first, then went back to the list of actions and answer Column B.

At no time will your name be identified; your answers are never identified with your name. Please do not write your name on the questionnaire.

SAMPLE QUESTION

Nurse X was taking care of Mr. Y in a community geriatric facility, where he was on medication for his arthritis. In the course of taking a nursing history Nurse X discovered that the patient had a history of an old ulcer and had been occasionally bleeding from it. The nurse subsequently found this documented in the chart too. Mr. Y was on medications for his arthritis that were contraindicated for ulcer conditions. She brought this to the attention of the head nurse who said she would take care of it; later in the day the head nurse talked to the physician, who was semi-retired and part-owner of the facility. The physician responded by saying that he knew what he was doing. It soon became apparent that the head nurse would not pursue the matter any further. Nurse X then talked to her supervisor who said that she would not get involved.

We are interested in Nurse X's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse X should do: Yes	Column A: Nurse X should do: No	Column B: Nurse X is realistically likely to do: Yes	Column B: Nurse X is realistically likely to do: No
1. Ask for additional order for maalox to cover GI distress.	✓	—	✓	—
2. Forget the whole matter; this battle is not as important as some others that Nurse X cares for.	—	✓	✓	—
3. Talk to her director of Nursing and ask her to intervene; Nurse X tells her director that if the medicine problem is not corrected, she will report the physician to the medical society.	✓	—	—	✓

Nurses A and B

Story One

Nurses A and B, good friends, were working the night shift on a Pediatric unit. Johnny, a one year old patient, went into heart failure and was transferred to the ICU. Immediately after the transfer Nurse A told Nurse B that she (Nurse A) had made a medication error and had given Johnny a larger dose of digoxin than was prescribed. She said that she had not reported the error and did not intend to report it; she made it clear that she did not want Nurse B to say anything about it either. She said that she was talking to Nurse B in confidence and that it would be unethical for Nurse B to break this confidence.

We are interested in Nurse B's actions.

For <u>each</u> of the actions listed below, check <u>yes</u> or <u>no</u>: for Column A - whether she <u>should</u> do or not; for Column B - whether she is <u>realistically likely</u> to do or not.

NURSING ACTIONS:	Column A: Nurse B <u>should</u> do: Yes	Column A: Nurse B <u>should</u> do: No	Column B: Nurse B is <u>realistically likely</u> to do: Yes	Column B: Nurse B is <u>realistically likely</u> to do: No
1. If Nurse A is basically a competent nurse, this one error can be overlooked; in that case, Nurse B will not do anything.	—	—	—	—
2. Nurse B explains to Nurse A the meaning of professional responsibility and accountability and suggests that she immediately report the error to the ICU staff and Johnny's physician.	—	—	—	—
3. After Nurse A states she will do nothing, Nurse B calls the ICU anonymously. She tells of the overdose, and hangs up.	—	—	—	—
4. Nurse B discusses the matter with the charge nurse and seeks advice as to what she should do.	—	—	—	—
5. Nurse B explains to Nurse A that when a patient's life is endangered, information on a drug overdose cannot be considered confidential.	—	—	—	—
6. Nurse B examines the chart for drug dose recorded, and for other relevant facts, so that she can evaluate the gravity of the error.	—	—	—	—

<u>COMMENTS:</u>

The Nephrologist and Nurse M

Story Two

Dr. Z, the chief nephrologist of a community hospital, constantly makes rounds on the dialysis unit visibly intoxicated, appearing dirty and disorganized. His speech is frequently slurred and inappropriate. His responsibilities include diagnosing patients and checking the patients on the unit for infection. Nurse M, a staff nurse, has noticed Dr. Z's behavior for a period of time and has approached both the head nurse of the unit and Dr. Z's partner to express her concern. She was told by both of them to mind her own business.

Nurse M has three school age children and she is the sole support of her family. She lives in a small close-knit community and is aware that Dr. Z and his wife are good friends with the Director of Nursing and her husband. The community hospital where Nurse M works is the only agency where she can work within a 75-mile radius.

We are interested in Nurse M's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse M should do: Yes	Column A: Nurse M should do: No	Column B: Nurse M is realistically likely to do: Yes	Column B: Nurse M is realistically likely to do: No
1. Call her professional organization to discuss her concerns and seek advice.	___	___	___	___
2. Write a factual letter to the medical board of the institution.	___	___	___	___
3. Request a transfer from the dialysis unit.	___	___	___	___
4. She need do nothing; it is not Nurse M's responsibility to "clean up" medical practice.	___	___	___	___
5. Write an anonymous and angry letter to the local medical society complaining about Dr. Z's behavior.	___	___	___	___
6. Encourage the patients to complain to Dr. Z and his partner about Dr. Z's behavior.	___	___	___	___
7. Speak to Dr. Z privately and express concern about his health and patient safety.	___	___	___	___

COMMENTS:

Mrs. J and Nurse D

Story Three

Mr. J has been in ICU for a total of 11 days and comatose for the past seven days. His family was allowed to visit him only for short periods of time. His vital signs faltered and emergency treatment measures were stepped up, to no avail. A few minutes later Mrs. J arrived and was informed of her husband's death by an intern on duty. The intern then immediately asked Mrs. J to sign a permit authorizing an autopsy. She refused. The chief resident then tried to convince her that the autopsy would aid medical science and pressed further for her permission. However, she continued to refuse. The attending physician stepped in and also pressed her to sign the autopsy permit. Mrs. J replied that she wanted her husband to have the dignity she felt he was denied in his last few days in ICU. Mrs. J then asked to talk privately to Nurse D who had taken care of Mr. J during the last several days of his life.

The nurse felt the need to support Mrs. J in her refusal to sign the consent form because she viewed her professional responsibility to be toward the patient and his family. She also realized that an autopsy was against the J family's basic beliefs. On the other hand, the nurse, as a professional, is not against having autopsies performed because they are of value in research.

We are interested in Nurse D's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse D should do: Yes	Column A: Nurse D should do: No	Column B: Nurse D is realistically likely to do: Yes	Column B: Nurse D is realistically likely to do: No
1. Explain to Mrs. J why an autopsy is important and suggest she discuss the matter with her family before making a decision.	___	___	___	___
2. Suggest to Mrs. J that the doctors worked very hard on her husband and that they deserve to do the autopsy.	___	___	___	___
3. Suggest that Mrs. J discuss the matter with the hospital chaplain and offer to call the chaplain.	___	___	___	___
4. Allow Mrs. J to discuss how she feels about consenting and explore her reasons. Whatever decision Mrs. J finally makes, the nurse supports.	___	___	___	___
5. Contact the nursing supervisor and let her talk to Mrs. J.	___	___	___	___
6. Suggest to Mrs. J that if the autopsy is performed Mr. J's death will not have been in vain in that it may help other people.	___	___	___	___
7. Tell Mrs. J that she (Nurse D) finds herself in conflict. She feels supportive of Mrs. J but also thinks there is merit in allowing an autopsy.	___	___	___	___

COMMENTS:

Mr. G and Nurse H

Story Four

Mr. G has had cancer for some time; he has been aware of his diagnosis and was dealing with it quite well. Mr. G was admitted to the hospital for recurrence of cancer.

The physician in charge wanted to test an experimental cancer drug on Mr. G and was trying to convince Mr. G that he would be helped by the "new drug." The nursing and medical staffs on the unit knew that Mr. G's questions were not answered truthfully by his physician. They also knew that this physician's prime interest was to test the drug through further research, and he was intent on getting Mr. G as a subject, through whatever means.

Mr. G was being asked to sign a consent form, and while he was not fully informed as to what this meant, because of his prior trust in his physician and his fear that saying no would put his care in jeopardy, he was considering signing it. He shared these thoughts with his nurse (Nurse H), and asked questions about the drug and what she thought he ought to do.

We are interested in Nurse H's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse H should do: Yes	Column A: Nurse H should do: No	Column B: Nurse H is realistically likely to do: Yes	Column B: Nurse H is realistically likely to do: No
1. Contact her head nurse and supervisor and discuss her concern that an experimental drug may be given without a patient's informed consent.	—	—	—	—
2. Reassure Mr. G that his physician has the situation under control and is acting in his best interest.	—	—	—	—
3. Contact the chairperson of the research committee of the institution and alert him that an experimental drug may be given without the patient's full understanding and informed consent.	—	—	—	—
4. Suggest that she will arrange a meeting involving the patient, the physician and herself so that Mr. G can have his questions answered. She subsequently calls the physician and arranges such a meeting.	—	—	—	—
5. Tell Mr. G that he is going to get better with the drug and to stop worrying.	—	—	—	—
6. Write an anonymous letter to the research committee of the institution complaining that Mr. G's physician is coercing Mr. G to consent to an experimental drug without fully informing him about it.	—	—	—	—

COMMENTS:

Katie and Nurse P

Story Five

It was a holiday weekend on a fairly busy 30-bed pediatric ward with several recent post-op and acutely ill patients. Two registered nurses and one aide were on duty. Everything was under control until 6-year old Katie was admitted as an emergency. She had severe head trauma and required neurological checks every 15 minutes. Katie's parents were with her, visibly anxious about her.

The nurse in charge, Nurse P, assessed the unit to be dangerously understaffed and felt that additional coverage would be necessary to safeguard the patient's life. Nurse P called several staff members who were off-duty, but no one was available to come in and work on the unit at that time. This was not the first time that short staffing had caused an unsafe situation.

We are interested in Nurse P's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse P should do: Yes	Column A: Nurse P should do: No	Column B: Nurse P is realistically likely to do: Yes	Column B: Nurse P is realistically likely to do: No
1. Notify the resident that due to Katie's condition and low staff-patient ratio it would be advisable to move Katie to the pediatric ICU.	___	___	___	___
2. Tell the parents, "If Katie were my child, I wouldn't leave her here."	___	___	___	___
3. Tell the supervisor that the situation is impossible and that she (Nurse P) is going to go home.	___	___	___	___
4. Rearrange all priorities, deal with the immediate crisis, then write up the situation and send it to the administrator so that this will not occur again.	___	___	___	___
5. Discuss the situation with the supervisor and explore ways in which she may be of assistance, such as by sending a nurse from another unit or by personally helping with care of patients.	___	___	___	___
6. Contact the supervisor and inform her that safe care cannot be assured and that she (Nurse P) will not accept any responsibility.	___	___	___	___

COMMENTS:

SK:so

Mr. T and Nurse L

Story Six

Mr. T, a 72 year old man, was diagnosed as having advanced cancer of the larynx; he is scheduled for surgery which he knows is not curative but which may prolong his life.

Prior to surgery, Mr. T became withdrawn and introspective. He told Nurse L he was not sure he wanted to go through with surgery; that his thoughts were that he had had a satisfying and long life, and felt he could accept death. He asked Nurse L to advise him as to what he should do.

Nurse L finds herself in a conflict. She believes that she must do everything possible to sustain life, but she also feels that patients have a right to make decisions about their own lives.

We are interested in Nurse L's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not, for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse L should do: Yes	Column A: Nurse L should do: No	Column B: Nurse L is realistically likely to do: Yes	Column B: Nurse L is realistically likely to do: No
1. Remove herself from the situation. Ask to have her assignment changed.	—	—	—	—
2. Help Mr. T. problem solve, assess his fears and understanding of the implications of having or not having surgery.	—	—	—	—
3. Support Mr. T in whatever decision he makes.	—	—	—	—
4. Tell Mr. T he should have the surgery.	—	—	—	—
5. Talk to Mr. T's family members and ask them to convince him to have surgery.	—	—	—	—
6. Acknowledge Mr. T's right to decide either way, as well as his right to change his mind later. Assure Mr. T that care will be available to him in either case	—	—	—	—
7. Suggest a conference with Mr. T, his family, herself and the physician to discuss the matter.	—	—	—	—

COMMENTS:

APPENDIX IX (B)

護士抉擇的判斷

以下有六個故事，故事裡護士都處在進退兩難的困境，而每個故事下面，都列了她/他如可能採取的行動的例子。請你在每個例子右方填上你的選擇。

在很多情況下，處於專業角度考慮護士相信和認爲應該怎樣處事。但基於機構裡種種固有的成規和限制。她/他往往不能按照自己的信念而行。基於這種矛盾的存在。護士每解決一個問題，可能有兩種情況出現：第一，假如完全沒有環境限制作爲一個護士，她/他最理想該怎樣做(A項)。第二，設受到環境限制。實際上她他最可能怎樣做(B項)。請你就這兩個情況,分別填上你的選擇。

對於這些情況，不同護士會有不同的見解，我們想知道的是你對故事中的護士分別在A項和B項的每個做法的意見。但是，A項和B項的答案，不一定要不同，它們或同或不同這裡要的，是你在每一個例子忠實的判斷。

請注意，以下所列的解決方法，並非互相抵觸的。護士選擇了其中一個方法，並非表示她/他不可H採取任可其他所列舉的行動。

建議：答完了A項所有的問題，才回答B項的。這對作答時，可能會更爲簡單方便。

本問卷採取不記名方式，請不要署名。

樣 本

A護士在一社區老人中心照顧乙先生。乙先生患了關節炎，正在接受藥物治療。在搜集乙先生的護理歷期嶂承A甲護士發現乙先生曾患潰瘍，並偶然有出血的現象。甲護士後來發現乙先生的病歷中亦有記載這情 ' p。乙先生現服用的藥物，是不適用於(禁忌)潰療病患者。她把這事報告病室主任，病室主任說她會處 B

理這事。當天，病室主任找那個處於半退休狀態，

但郤是中心的董事的醫生商討這問題。醫生說他自己知道自己所做的是什麼。很明顯病室主任亦已不再跟進這事了。甲護士找部門主管談及此事，但主管說她也不願意涉入此事內。

我們有興趣知道，甲護士的行動。

在以下所列出每一個決行動旁。

請選擇是或否： A項是表示她應該做與否。B項則表示實際可能會否做。

解決行動	A 項	B 項
	甲護士應該做	甲護士實際可能會做
1.要求要多些MYLANTA來預防乙先生的胃痛。	是□ 否□	是□ 否□
2.把整件事拋諸腦後 她還有其他更重要的事去處理，這事算不得什麼。	是□ 否□	是□ 否□
3.要求總護士長干預，告訴她如果這藥物問題不被抖正，她自己會向醫學會告發這醫生。	是□ 否□	是□ 否□

評語：

故事一：N護士與K護士

N，K兩護士是好朋友，她們同在一兒科病室室值夜。輝仔，一歲，因心臟衰竭而轉往深切治療部(ICU)。輝仔轉病房後， N護士就告訴K護士，說她曾錯誤地給輝仔服用的毛地黃(Digoxin)藥量超於藥方的指示，她表示不曾報告這件事，也不打算這樣做，並表明不希望K護士揭發此事。N護士要求K護士爲此事守秘密並表示若K護士把它洩漏出去，是不道德的行爲。

我們有興趣知道，K護士的行動。

在下列每一個解決行動旁，請選擇是或否：A項表示她應該做與否。B項則表示她實際可能做與否。

解決行動：

1. 假如N護士基本上是辦事得力的護士這一錯誤可以不理，而K護士亦不需就此而做任何事。
2. K護士向N護士解釋身爲護士的職務和責任，並建議她立即向ICU職員和輝仔的醫生報告所犯的錯誤。
3. N護士表示不會採取任何行動之餘，K護士打匿名電話給ICU揭發輝仔服用過量藥物一事。
4. K護士和主管護士商量尋求她對N護士所應採取的行動的意見。
5. K護士向N護士解釋，在危及病人生命的情況下，病人服用過量藥物，是不應該視爲保密處理。
6. K護士查看輝仔服用藥物的記錄，及其它有關的資料，以便評估這次錯誤帶來的嚴重性。

A 項	B 項
K護士應該做	K護士實際可能會做
是□ 否□	是□ 否□
是□ 否□	是□ 否□
是□ 否□	是□ 否□
是□ 否□	是□ 否□
是□ 否□	是□ 否□
是□ 否□	是□ 否□

評語：

故事二：腎科專家與M護士

丁醫生，是一所分區醫院的腎科主任，經常巡察病房時，明顯地帶醉態，蓬頭垢面，並處事欠缺組織，說話言語不清，及不恰當。丁醫生的責任包括斷症及檢驗該科病人是否患有傳染病。M護士及該部門的護理人員察覺到丁醫生的表現已有一段時期，並曾向病室主任和丁醫生的同事表示過她的關注，但她們都勸她不要多管閒事。

M護士有三個兒女，都在求學階段，而她是家中的唯一經濟支柱。M護士居住在一關係密切的社區內，她並知道丁醫生夫婦和總護士長夫婦是好朋友。她現在工作的分區醫院是唯一距離其居所很近的一間。

我們有興趣知道，護士的行動。

在以下所列出每一個解決行動旁，請選擇是或否。

A項表示她應該做與否。B項則表示她實際可能會否做。

解決行動

A　項	B　項
M護士應該做	M護士實際可能會做
1.聯絡她所屬的護士組織，與他討論這事及資詢其意見。	
是□　否□	是□　否□
2.寫信把實情告知院方的醫務委員會。	
是□　否□	是□　否□
3.要求調離該腎科部門。	
是□　否□	是□　否□
4.M護士不需做什麼，她沒有責任去爲醫學界「清理門戶」。	
是□　否□	是□　否□
5.寫封匿名信表示憤慨，向當地醫學會投訴丁醫生的行爲。	
是□　否□	是□　否□
6.鼓勵病人向丁醫生和他的同事投訴丁醫生的行爲。	
是□　否□	是□　否□
7.私下與丁醫生傾談，表示關注他的健康和病人的安全。	
是□　否□	是□　否□

評語：

故事三　E先生與D護士

E先生留住ICU已有十一天，過去七天一直昏迷不醒，他家人只能來探望他短時間。E先生的命表徵轉差，經急救後仍無效。幾分鐘後，E太太抵達醫院，一名實習醫生告知E太太關於其先生的噩耗，並要求E太太立刻簽名同意爲E先生的遺體進行解剖，但E太太拒絕了。及後，主任醫生嘗試極力游說E太太簽署解剖同意書，謂會幫助醫學研究，但她還是拒絕了。其後。主診醫生亦加入游說E太太，E太太說她希望能保留其丈夫過去幾天來留住ICU所喪失的尊嚴。 E太太要求與過去幾天照顧過E先生的D護士傾談。

D護士覺得，有需要支持E太太及其家人去拒絕簽同意書。她視此爲專業責任。D 護士明白到接受解剖是違背E家的意願。但另一方面，作爲專業護士她並不反對把遺體解剖，因爲這對於研究有價值。

我們有興趣知道，D護士的行動。

在以下所列出的每一個解決行動旁。請選擇是或否，A項表示她<u>應該</u>做與否。B項則表示她<u>實際可能</u>會否做。

解決行動

A　項	B　項
D護士<u>應該</u>做	D護士<u>實際可能</u>會做
是□　否□	是□　否□
是□　否□	是□　否□
是□　否□	是□　否□
是□　否□	是□　否□
是□　否□	是□　否□
是□　否□	是□　否□
是□　否□	是□　否□

1.向E太太解釋解剖的重要性，並建議她跟家人商量後，再作決定。
2.向E太太提示，醫生們都很盡力醫治她丈夫，他們解剖E先生的遺體，是理所當然的。
3.建議E太太跟醫院牧師商量， 並主動爲E太太聯絡牧師。
4.讓E太太表達她對簽同意書的感受及進一步了解她的解釋。但無論E太太最終怎樣決定， D護士都會支持。
5.聯絡部門護士主任與E太太傾談。
6.向E太太透露。若能解剖E先生遺體，其他人會因此受惠，那E先生的死，不是沒價值。
7.將她心中的予盾告訴E太太。她支持E太太的決定，但亦說認爲解剖是有其價值。

評語

故事四：G先生與H護士

G先生患了癌症已有一段日子，他覺察自己的診斷並一向處理很好。G先生因癌症復發而入院。

主診醫生想試用一癌症用藥物於G先生身上，故嘗試游說G先生「新藥」的療效。病室內的醫護人員知道主診醫生並沒有老實地回覆G先生的疑問。他們知道主診醫生的主要目的，是要試驗研究這藥物。於是，千方百計使G先生答應做試驗品。

G先生被要求簽同意書，但期間沒有獲得充份解釋。由於G先生對醫生一向信任，加上恐怕拒絕簽名，對自己不利，故他打算答應。他將這些想法告訴照顧他的H護士，並詢問關於那藥物以及徵詢她應如何處理。

我們有興趣知道，H護士的行動。

在以下所列出的每一個解決行動旁，請選擇是或否，A項表示她應該做與否。B項則表示她實際可能會否做。

解決行動

A 項	B 項
H護士應該做	H護士實際可能會做
1.聯絡病室護士主任和部門護士主任，提出對病人不知情下而進行藥物試用的關注。	是□ 否□	是□ 否□
2.向G先生保證，醫生已控制其病情，並會爲G先生著想。	是□ 否□	是□ 否□
3.聯絡院方的研究委員會主席，知會他在病人未完全明白及同意情況下誰進行藥物試用。	是□ 否□	是□ 否□
4.建議一會議，召集醫生，病人及H護士去解答G先生的疑問。其後她與醫生聯絡安排此會議。	是□ 否□	是□ 否□
5.告訴G先生，拋開憂慮，因那種藥會使他的病情轉好的。	是□ 否□	是□ 否□
6.寫一封匿名信給院方研究委員會，投訴醫生，在沒有讓G先生瞭解底細下，强迫他同意服用試驗藥物。	是□ 否□	是□ 否□

評語：

故事五：小玲與P護士

在一假日的週末，一個有三十張病床，頗爲繁忙的兒科病房裏，住著幾位剛做完手術而又病重的病童。當值有兩位註冊護士和一位病室助理。起初她們對病房的情況，一切都在控制範圍之內，直至六歲的小玲急症入院。她頭部受嚴重創傷，需每十五分鐘接受一次神經系統檢查。小玲的父母陪伴在她身旁，顯然很憂慮。

病房的P主管護士，評定病室的人手不足，達至危險程度，覺得爲病人生命安全著想，必須增加人手。P護士打電話請幾位休班護士回病室工作，但當時沒有人可以回來幫忙。類似人手不足，達至不安全境況，已不是第一次了。

我們有興趣知道P護士的行動。

在以下所列出的每一個解決行動旁，請選擇是或否。 A項表示她應該做與否。B項表示她實際可能會否做。

解決行動

A 項	B 項
P護士應該做	P護士實際可能會做
1.通知醫生，由於小玲的情況及護士，病人比例低，建議把她轉往(兒童)ICU。	是□ 否□	是□ 否□
2.告訴小玲父母：「如果小玲是我的女兒，我不會讓她留在這病房」。	是□ 否□	是□ 否□
3.告訴部門護士主任，這情況實在不可能接受，她要離開回家去。	是□ 否□	是□ 否□
4.重新安排工作優先次序，處理當前急務。然後記錄這情況，送給院長，以致此情況，不會再出現。	是□ 否□	是□ 否□
5.跟部門主任商量，尋求她可以幫助的方法。例如調派其他部門的護士或她親身來幫助照顧病人。	是□ 否□	是□ 否□
6.聯絡部門主任，告知她不可能確保安全的護理，並且不會承擔任何責任。	是□ 否□	是□ 否□

評語

故事六：王先生與M護士

七十二歲的王先生患了末期咽喉癌，他被安排了接受手術，王先生知道手術不是治療性，但可延長壽命。

手術前，王先生變得退縮，沈默內省。他向M護士透露，他不肯定是否想接受手術。他已有一滿足而長的生命，他覺得能夠接受死亡，他問M護士的意見。

M護士發覺左右爲難，他一方面相信她必需盡可能維持病人的生命，但又覺得病人對自己的生命有自決權。

我們有興趣知道M護士的行。

在以下所列出的每一個解決行動旁，請選擇是或否。A項表示她應該做與否。B項表示她實際可能會否做。

解決行動

A　項	B　項
M護士應該做	M護士實際可能會做
1.要求轉換工作分配，把自己抽離此境況。	
是□　否□	是□　否□
2.幫助王先生解決問題，評估他的恐懼，了解他對接受或不接受手術後果的看法。	
是□　否□	是□　否□
3.支持王先生所作的任何決定。	
是□　否□	是□　否□
4.告訴王先生他應該接受手術。	
是□　否□	是□　否□
5.與王先生的家人商量，建議他們勸服王先生接受手術。	
是□　否□	是□　否□
6.認可王先生決定權及改變主意的權利，保證無論怎樣決定，都會悉心照顧他。	
是□　否□	是□　否□
7.建議召集王先生的家人，她自己和醫生進行會議，商量整件事情。	
是□　否□	是□　否□

評語

APPENDIX: X

WARD LEARNING CLIMATE INDICATORS

Ward Learning Climate indicators with related items from the questionnaire

" Communication lines approachability"

6. Student nurses are taught not to speak to the doctors unless spoken to first.

7. Ward activity is regulated for the requirement of the medical staff.

8. Student nurses do not normally accompany doctors on a ward round.

9. Student nurses would not make a suggestion about a patient only if the ward sister asked.

10. Nurses of all ranks feel free to seek clarification of orders from doctors.

11. Student nurses are encouraged to ask questions.

12. Responses to students' questions are usually negative.

32. The ward sister does not usually explain to subordinates instructions coming from a higher level.

" Patient/ Task orientation"

13. Patient allocation, rather than task allocation, is the practice of a ward.

14. The patient should be the most important person on the ward.

15. Each patient should receive individualised nursing care.

" Teaching"

16. The ward sister devotes a lot of her time to teaching student nurses.

17. The ward sister has a teaching programme for students on the ward.

18. The teaching of student nurses is often delegated by the ward sister to trained staff.

19. Student nurses learn more from other students on the ward staff.

20. The ward sister is not always confident of her ability to teach student nurses.

21. Ward staff devote more time to teaching first year student nurse than other years.

22. Ward staff devote more time to teaching third year student nurses than other years.

"Attitude to student"

1. As long as student nurses are proficient in carrying out procedures, it does not matter whether they understand the underlying principles.

2. Student nurses should learn about the patient from the ward sister rather than from the medical staff.

3. On the ward student nurses learn best by being left to fet on with the job.

4. Students are sometimes regarded as a nuisance when the ward is busy.

5. Student nurses makes little real contribution to the work of the ward before well into her second year.

23. The ward sister attaches great importance to the learning needs of student nurses.

24. Student nurses learn a lot by observing how the ward sister carries out her role.

25. Learning aids, such as books/ articles are available to student nurses on this ward.

26. Procedures used on the ward are sometimes different from those taught in the school.

27. Student nurses are not expected to obey ward sister's instructions without ever asking question.

28. Student nurses often have to learn by being left to get on with the job.

29. Student nurses are regarded as a worker rather than a learner.

30. When a student nurse arrives on the ward for the first time the ward sister knows what stage of training she has reached.

31. In planning the ward duty rota allowance is made for student nurses to gain the widest possible experience.

"Emotional support"

33. The ward sister is not concerned about what a student nurse is thinking or feeling as long as she is getting on with her work.

34. Reprimands are never given in front of others.

35. Conferences between ward staff and student nurses to discuss personal or clinical problems are not a feature of the ward.

36. If a student nurse is in any difficaulty she goes to the ward sister to discuss the problem.

APPENDIX XI (A)

WARD LEARNING CLIMATE QUESTIONNAIRE

HOSPITAL WARD AS A SETTING FOR STUDENT NURSE LEARNING

The purpose of this questionnaire is to find out what you think about the hospital ward as a setting for student learning.

Please put a ' ' in the relevant column which reflect most accurately your opinion.
e.g. if you strongly support the view that 'student nurse should be considered as a learner rather than a worker', you will tick as indicated -

Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
✓				

WARD LEARNING SETTING	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
1. As long as student nurses are proficient in carrying out procedures, it does not matter whether they understand the underlying principles.					
2. Student nurses should learn about the patient from the ward sister rather than from the medical staff.					
3. On the ward student nurses learn best by being left to get on with the job.					
4. Student nurses are sometimes regarded as a nuisance when the ward is busy.					
5. Student nurses makes little real contribution to the work of theward before well into her second year.					
6. Student nurses are taught not to speak to the doctors unless spoken to first.					
7. Ward activity is regulated for the requirement of the medical staff.					
8. Student nurses do not normally accompany doctors on a ward round.					

WARD LEARNING SETTING	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
9. Student nurses would not make a suggestion about a patient only if the ward sister asked.					
10. Nurses of all ranks feel free to seek clarification of orders from doctors.					
11. Student nurses are encouraged to ask questions.					
12. Responses to students' questions are usually negative.					
13. Patient allocation, rather than task allocation, is the practiceof a ward.					
14. The patient should be the most important person on the ward					
15. Each patient should receive individualized nursing care.					
16. The ward sister devotes a lot of her time to teaching student nurses.					
17. The ward sister has a teaching programme for students on the ward.					
18. The teaching of student nurses is often delegated by the ward sister to trained staff.					
19. Student nurses learn more from other students on the ward than from the ward staff.					
20. The ward sister is not always confident of her ability to teach student nurses.					
21. Ward staff devote more time to teaching first year student nurses than other years.					
22. Ward staff devote more time to teaching third year student nurses than other years.					
23. The ward sister attaches great importance to the learning needs of student nurses.					
24. Student nurses learn a lot by observing how the ward sister carries out her role.					
25. Learning aids, such as books/ articles are available to student nurses on this ward.					

WARD LEARNING SETTING	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree
26. Procedures used on the ward are sometimes different from those taught in the school.					
27. Student nurses are not expected to obey ward sister's instructions without ever asking questions.					
28. Student nurses often have to learn by being left to get on with the job.					
29. Student nurses are regarded as a worker rather than a learner.					
30. When a student nurse arrives on the ward for the first time the ward sister knows what stage of training she has reached.					
31. In planning the ward duty rota allowance is made for student nurses to gain the widest possible experience.					
32. The ward sister does not usually explain to subordinates instructions coming from a higher level.					

(B). What do you like best about the wards?

(C). What do you like least about the wards?

APPENDIX XI (B)

「醫院病室作爲護士學生學習環境」調查

本問卷目的是想知道閣下對病室作爲護士學學生習環境的意見。請於適當空欄上加上「v」，及盡量避免「未能決定」的一項。本問卷無需署名，絕對保密。謝謝合作！

(A) 此部份是問及閣下對病室學習環境的意

	強烈贊成	贊成	不能決定	反對	強烈反對
1.只要護士學生在進行護理程序時熟練，他們是否明瞭其中原則，並不重要。					
2.護士學生應該從病室主任，而不是醫生處，學習有關病人的情況。					
3.在病室裡，護士學生最佳的學習途徑是讓他們自行工作。					
4.病室忙碌時，護士學生有時被視爲障礙。					
5.護士學生在進入二年級時才眞正對病室有貢獻。					
6.護士學生被教導不與醫生交談，除非醫生先與他交談。					
7.病室的活動是適應醫生的需求。					
8.護士學生不參與主任醫生查房。					
9.若非病室主任問，護士學生不會作出任何有關病人的建議。					
10.不同等級的護士都可以毫無拘束地向醫生澄清醫囑。					
11.在病室中，護士學生被鼓勵去發問問題。					
12.對護士學生提出問題的回應，通常都是負面的。					
13.病室實施的是病人分配，不是工作分配。					
14.病人應該是病室中最重要的人物。					
15.病人應接受全人護理。					
16.病室主任給予許多時間來教導學生。					
17.病室主任有一學習計劃來教導學生。					
18.病室主任通常委派護士職員教導學生。					
19.護士學生從其他學生所學習的，比從護士職員學習的更多。					
20.病室主任對自己教導學生的能力，有時缺乏自信。					
21.病室職員給予較多時間去教導一年級護士學生。					
22.病室職員給予較多時間去教導三年級護士學生。					
23.病室重視護士學生學習的需要。					
24.護士學生從觀察病室主任施行職務時學習很多。					

強烈贊成	贊成	不能決定	反對	強烈反對

25.病室中有輔助學習材料，如書本，雜誌供應給護士學生。

26.病室所使用的程序，有時與學校所教導的有分別。

27.護士學生不盲目服從病室主任的指示。

28.護士學生通常必須透過自行工作來學習。

29.護士學生是工作人員而非學員。

30.當護士學生初到病室時，病室主任已知道學生受過什麼情度的訓練。

31.編排更期時，有給予護士學生機會去獲得多方面的經驗

32.病室主任通常不向下屬解釋上級的指示。

(B) 以下的問題，是問及閣下對病室工作的感受及對護理的一般想法。

1.病室實習對於學生學習是很有幫助的。

2.我很滿意在病室實習所得到的經驗。

3.病室工作太工式化。

4.在病室工作的時候，我曾想放棄護理工作的念頭。

5.病室甚少提供教導機會。

6.在病室中，從沒有困難將學到的程序，應用於工作上。

7.我有時懷疑自己是否應選擇護理工作。

8.護士學生從不被鼓勵去思想。

9.護士學生通常可以隨時發問。

10.護士學生通常所發問的題，通常得到合理的解答。

11.各階層的護士職員都有合作的精神。

12.護理工作的壓力很大。

13.護理是循著更好的方向改進。

14.病人的需求是居首位。

(C) 在病室中,有甚麼令你最喜歡?

(D) 在病室中,有甚麼令你最不喜歡?

APPENDIX: XII

NARRATIVE RESPONSES TO THE QUESTIONS 'WHAT DO YOU LIKE BEST ABOUT THE WARD?' AND 'WHAT DO YOU LIKE LEAST ABOUT THE WARD?

THE WARDS

RESPONSES to the question ' What do you like best about the ward?'

1. In relation to patient care

   : patient is friendly, encouraging and understanding

   : build up a good relationsip with patients

   : patient recovers, condition stable

   : can talk to patients and practise holistic care

2. In relation to interpersonal relationship and staff attitude

   : good working relationship with ward staff

   : able to discuss and express opinions

   : harmonious relationship

   : unity in working for the well-being of patients

   : competent and conscientious ward sister and staff

3. In relation to learning

   : ward staff are willing to teach and supervise students

   : gain knowledge through work

   : gain respect and trust from ward sister and staff

4. In relation to ward organization

   : adequate staffing and equipment

   : comfortable working environment

RESPONSES to the question 'What do you like least about the ward?'

1. In relation to patient care

: unreasonable complaints from patients

: a lot of ill and dying patients in the ward

2. In relation to interpersonal relationship and staff attitude

:lack of co-operative spirit among ward staff

: unhelpful ward staff

: lack of understanding from ward staff

: bureaucratic

: lazy and irresponsible ward staff and doctors

: unreasonable doctors

3. In relation to learning

: unwilling to teach

: environment not conducive to learning

: perform task without knowing the reasons

: lack of trust and respect from ward sister and staff

4. In relation to ward organization

: stress

: unfair policies that influence morale

: different standard

: overcrowded ward and inadequate staffing

: disorganized ward environment