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Does Ethics Education Influence the Moral Action of Practicing Nurses and Social Workers?

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Abstract

Purpose/methods—This study investigated the relationship between ethics education and training, and the use and usefulness of ethics resources, confidence in moral decisions, and moral action/activism through a survey of practicing nurses and social workers from four United States (US) census regions.

Findings—The sample (n = 1215) was primarily Caucasian (83%), female (85%), well educated (57% with a master's degree). no ethics education at all was reported by 14% of study participants (8% of social workers had no ethics education, versus 23% of nurses), and only 57% of participants had ethics education in their professional educational program. Those with both professional ethics education and in-service or continuing education were more confident in their moral judgments and more likely to use ethics resources and to take moral action. Social workers had more overall education, more ethics education, and higher confidence and moral action scores, and were more likely to use ethics resources than nurses.

Conclusion—Ethics education has a significant positive influence on moral confidence, moral action, and use of ethics resources by nurses and social workers.

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Keywords

ethics education; moral action; ethics consultation

Nurses and social workers (SWs) are vital members of our healthcare workforce. Faced with challenging ethical issues in practice, nurses and SWs routinely make difficult ethical decisions. Much has been written about the moral distress that nurses and SWs experience in practice (Corley 2002; Corley et al. 2005; Gregorian 2005; Kalvemark et al. 2004). Moral distress is attributed, at least in part, to the divided loyalties that nurses and SWs feel in their work. They are often caught between what they think might be best for their patients and the institutional constraints or overriding decisions of other healthcare professionals (Jameton 1984).

Little is known about how confident SWs and nurses feel in their ability to handle ethical issues and to take appropriate moral action. The purpose of this study was to explore the relationship between ethics education and training, use of ethics resources, confidence, and moral action. We hypothesized that nurses and SWs with more ethics education would be more confident in their moral judgments, more likely to use ethics resources, and more likely to take moral action. The analysis reported here is part of a larger study investigating ethical issues and ethical stress experienced by nurses and SWs, and the impact of ethical stress on job satisfaction and retention (Ulrich et al., 2007).

METHODS

Study Sample and Design

A self-administered survey was mailed in 2004 to a random sample of 3,000 nurses and SWs chosen from the state licensing lists of four states in different census regions of the United States (California, Maryland, Massachusetts, and Ohio). States were chosen for geographical diversity and based on the availability of state licensing lists for both professional groups. Currently certified and licensed registered nurses (RNs) and SWs in each of the designated states were eligible for participation. We estimated that approximately one-third of SWs practice in healthcare settings and therefore over-sampled this population to ensure an adequate number of responses for our analysis. Of our respondents, 12% were ineligible and 3.6% did not have a valid address, resulting in an overall adjusted response rate of 52% (53% SWs; 52% RNs). The margin of error for the results from the entire sample was ±2.8%.

The Survey Questionnaire and Procedures

A single questionnaire for both professional groups was designed by the authors in conjunction with the Center for Survey Research at the University of Virginia (Charlottesville, VA). Respondents were offered the option of either a paper and-pencil or an Internet-based response. Four mailings were sent to participants and all participants received $2 in the initial mailing.

Overall questionnaire items aimed to identify common ethical problems experienced by nurses and SWs, the level of ethical stress they experience and factors that influence stress, their perception of their practice-setting ethical climate, self-described moral action, use of ethical resources, job satisfaction, and sociodemographics. In the current article, we report on the relationship between ethics education and confidence, use of resources, and moral action, and the extent to which it differs between nurses and SWs.

Variables Measured

Respondents were asked to indicate the highest level of education they had, and whether they had any ethics course work or training in their basic or advanced professional program, in a fellowship program, a continuing education ethics program, or in an in-house training program. Respondents could select more than one item and could also specify other sources of training not listed. For analysis, we created the following ethics education categories: 1) professional program only, 2) continuing education or in-house training only, 3) both professional program and continuing education/in-house training, or 4) no ethics training. We combined "basic professional program" and "advanced professional program" for analysis as professional program.

Three questions were used to measure confidence, including 1) "I feel confident that I can justify my decisions regarding ethical issues"; 2) "I feel prepared to deal with the ethical issues I face;" and 3) "I feel confident about my professional responsibilities and scope of practice regarding ethical issues." Items were measured on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Scores for the three questions were summed for a total score between 3 and 15, with higher scores indicating greater confidence. Coefficient alpha for the three-item confidence score was a = 0.65

Respondents were asked if an ethics committee or ethics consultation resources were available to them. Those who reported having available resources were asked how often they used these resources, how helpful they found them, and any reasons they were reluctant to use available ethics resources.

Moral action was measured by the use of the moral action (activism) subscale of the Nursing Ethical Involvement Scale developed by Penticuff and Martin (1987). Respondents were asked to indicate the likelihood with which they would take specific actions when faced with an ethical dilemma in their practice. We added two items to the original subscale for a total of 12 items. including the following responses: feel concerned but take no further action; talk with other nurses and/or SWs, with a manager, with a physician, with the patient or family; and request a team meeting or request an ethics consult or ethics committee meeting. Items were measured on a 5-point scale ranging from 1 (not at all likely) to 5 (extremely likely) with one item reverse scored. Total scores can range from 12 to 60, with higher scores indicating a higher likelihood to take moral action. Cronbach's alpha showed an internal consistency of 0.80, similar to that reported by Penticuff and Walden (2000), $\alpha = .83$.

Data Analysis/Statistical Methods

Data were analyzed using SPSS version 14 (SPSS, Inc. Chicago, IL). Descriptive statistics were used to summarize the data. Overall 10.1% of the cases were missing one or more items on the moral action scale with most missing only one or two items. The percent missing on any item ranged from 0 to 2.3% for nurses and 0 to 5.2% for SWs. We used expectation maximization (EM) to impute missing items separately for each profession using other scale items, years of practice, and age. EM is one of the commonly used methods for imputing missing data that avoids overfitting while providing realistic estimates of variance.

We used analysis of variance to examine the difference in confidence scores and moral action scores across the four ethics education categories. Multiple regression was performed to examine the extent to which gender, master's education, discipline, age, hospital setting (yes/no), years in practice, ethics education, use of resources, usefulness of resources, and confidence predicted moral action (dependent variable).

Human Subjects Protection

The Office of Human Subjects Research (OHSR) at the National Institutes of Health (NIH, Bethesda, MD) and the IRB at the University of Virginia approved the study. A cover letter informed participants of the purpose of the study and that responses would be kept confidential.

RESULTS

Respondent Characteristics

A total of 1,215 nurses and SWs responded (Table 1). Respondents were mostly Caucasian (83.3%) and female (85.3%), and nurses were more likely than SWs to be female ($p < .001$); the overall mean age was 45.9 years [(SD 10.9) range 23–78 years]. Most of the SWs (83.3%) and 18.3% of the nurses had a master's education or higher. Of the nursing sample 6% were educated outside the United States. Respondents had a mean of 17 years of experience; 35% had practiced less than 10 years (mean, 7.4 years); 71.7% worked full time. Nurses and SWs in our sample did not differ significantly in age, sex, or ethnicity compared with the 2000 National Sample Survey of Registered Nurses (Spratley et al. 2001) and the 2004 Licensed Social Worker Survey in the United States (Stoesen and Moss 2006).

Ethics Education and Training

More than half (57.1%) of the sample reported having some course work or training in ethics during their professional basic and/or advance educational program, SWs more often than nurses (60.2% versus 51.2%, respectively; $p = .003$). Many others reported having either continuing education or in-house training or both, again SWs more often than nurses. One out of every seven respondents (14.3%) reported no ethics course work or training at all, with more nurses reporting no ethics education than SWs (22.7% versus 7.5%, respectively; $p < .001$) (Table 2).

Confidence and Moral Action

Confidence scores ranged from 3–15 with a mean of 11.7 and standard deviation of 1.83. Most agreed or strongly agreed that they felt confident in justifying ethical decisions (84.6%); felt prepared to deal with ethical issues (72.5%), and felt confident about professional responsibilities and scope of practice regarding ethical issues (80.1%).

Overall moral action scores ranged from 17–60 with a mean score of 38.4 and standard deviation of 8.08. SWs had slightly higher overall moral action scores than nurses ($F = 6.30$, $p = .012$); however, when controlled for ethics education, this difference was not significant. SWs were slightly more likely than nurses to talk with other members of their profession, their managers, or to call a team meeting, while nurses were more likely to talk with the physician. The moral action item that both nurse and social work respondents were most likely to take was "Talk with other members of my profession." Nurses tended more often than SWs to chose "feel concerned but take no further action"

There was a significant difference in confidence based on source of ethics education ($F=9.84$, $p<.001$), although only 2.4% of the variability in confidence scores was explained by the source of ethics training. Those with no ethics training (mean = 11.2) and training in their professional educational program only (mean=11.5) indicated significantly less confidence than those who had received either ethics training in continuing education or in-house only (mean = 11.9) or in both their professional program and through continuing or in-house education (mean = 12.0).

To further explore this relationship, we regressed confidence scores on ethics education controlling for age, profession, years in practice, and years in current position. Dummy variables were created for ethics education with no ethics training serving as the reference

group. The control variables accounted for a significant proportion of the variance in confidence scores ($F = 11.43$, $p < .001$); being older ($\beta = .084$) and being a Social Worker ($\beta = .178$ were associated with increased confidence. The model remained significant when ethics training was added ($p = .007$). In this final model, however, age was not significant ($p = .059$). Being a social worker ($\beta = .147$, $p < .001$) and having received training from only continuing education (CE) /in-house programs ($\beta = .109$, $p = .012$) or from both professional education program and CE/in-house programs ($\beta = .128$, $p = .027$) significantly accounted for variability in confidence scores.

Moral action scores also differed significantly based on ethics education ($F = 12.37$, $p < .001$). Based on the Tukey post hoc test, those reporting no ethics training had significantly lower (mean = 35.7) moral action scores than those with ethics education. Those who had ethics education both in their professional program and through CE/in-house training had significantly higher moral action scores (mean = 40.1) than those with no training or with training only in their educational program (mean 37.9).

Ethics Education and Use of and Usefulness of Ethics Resources

To assess the relationship between ethics education and the frequency of seeking ethics guidance and reasons for not using ethics resources more often, only the responses of those who indicated their organization or hospital had an ethics consultation service or ethics committee were analyzed (n= 602). Source of ethics training was related to frequency of using the consultation service or committee ($c^2 = 19.96$, $df = 9$, $p = .018$). Respondents who never or rarely used consultation services were more likely to have had no ethics training (85.9%) than to have had ethics training only in their professional program (77.4%), only CE/in-house ethics training (69.8%), or both (65.5%). Those with CE/in-house training (8.6%) were more likely than those with other kinds of education or with no education (2.3%) to indicate that they often or routinely used consultation services.

Ethics education was not related to perceived usefulness of consultation services ($c^2 = 20.38$, $df = 12$, $p = .06$), but was significantly related to reasons given for not using the services more often. Those who indicated they did not use the services more often because they were not qualified tended to indicate that they had no ethics education or that the education came through their professional program only (Table 3). Respondents with access to an ethics consultation service or ethics committee were asked to identify reasons they did not find the services useful. Reasons most frequently cited for finding ethics services never, rarely, or sometimes useful were that the process is too time consuming (37.5%), difficult to access (28.1%), because of confidentiality concerns (18.8%), not knowing an ethics consult would help (12.2%), unqualified consultants (9.9%), or consultation made things worse (7.4%).

Comparison of Nurses and Social Workers

As shown in Table 4 SWs and nurses differ in the source of their ethics education ($p < .001$) with nurses more likely to report no ethics education. Nurses and SWs also differ in their reported use of ethics consultation services ($p=.016$) with nurses more likely to never use the services. In addition, SWs have a higher level of confidence ($t=3.91$, $p < .001$) and higher overall moral actions scores ($t = 3.94$, $p < .001$). However, after controlling for ethics education, the difference between SWs and nursing in moral action scores becomes non-significant ($p = 0.42$).

Multiple regression was used to evaluate the association between ethics training/education, profession, use of resources, and confidence and moral action. With moral action as the dependent variable, predictor variables were entered in a hierarchical fashion. Table 5 summarizes the results. Overall the model explained 30.1% of the variance in moral action (F

= 17.89, df = 12 and 499, $p < .001$). As each block was added to the model, the increase in explained variance was significant ($p < .05$) with the exception of Block 2 (profession, working in a hospital setting, and years of experience). Ethics education, specifically training either from CE/in-house programs only or from a combination of professional education program and CE/in-house programs, was significant when entered into the model, but became nonsignificant when the frequency of using and the perceived usefulness of ethics consultation services were added to the model. Based on the final model, being female, having a master's degree, increased frequency of using ethics consultation services, increased perceived usefulness of the service, and increased confidence were significant predictors of moral action. When variables were entered using a stepwise approach, the same 5 predictors were entered, explaining 29.6% of the variability in moral action ($F = 42.47$, $p < .001$).

DISCUSSION

The findings from this study have important implications for the ethics education of nurses and SWs, and for the development and support of ethics resources in the settings where they work. Our data show that education and training in ethics has a significant influence on the confidence, use of ethics resources, and moral action of SWs and nurses.

First, although it is widely recognized that ethical issues are ubiquitous in healthcare, only 57% of the nurse and social worker respondents in our study had ethics education in their basic or advanced professional programs. Although many reported continuing education programs or in-service education in ethics, a surprising number of practitioners, including 23% of the nurse respondents, reported having had no ethics education or training at all. Ethics education can help nurses and SWs and other healthcare workers not only determine the extent to which problems they encounter in practice are ethical problems, but can also help them define their own ethical values and beliefs, and help them develop tools and skills needed to tackle ethical problems (Allmark 2005; Csikai and Raymer 2005; Landau 2000; Joseph and Conrad 1989).

Second and importantly, but perhaps not surprisingly, ethics education influences both confidence in one's ability to make ethical decisions and also moral action. Although most respondents felt fairly confident in their moral judgments, ethics education clearly increased confidence and those with no ethics education reported the least confidence. Ethics education and training can help healthcare practitioners develop confidence in their decisions, as well as the confidence and know-how to take appropriate action and tap into available resources when needed. The lowest moral action scores were seen in those with no ethics education, and highest in those with education both through their professional programs and continuing education. Those with little or no ethics education were more likely than those with education to explain that they infrequently used ethics resources because they did not feel authorized or qualified, or found the service difficult to access. Not feeling qualified or responding to an ethical conflict by feeling concerned but taking no further action makes one susceptible to moral distress—distress resulting from a discrepancy between what one thinks ought to be done and what is actually done. Moral distress is a common phenomenon in healthcare workers (Kalvemark et al. 2004). Interestingly, continuing education programs in ethics, with or without professional education in ethics, were associated with the highest confidence and moral action scores. Continuing education programs are likely to be more recent than professional education, or may be more practical in their orientation. Access to continuing education may also be an indicator of the organization's ethical climate and support for ethics. In any case, this is an important finding that deserves further study.

Ethics education also has a significant positive influence on the use of ethics resources by nurses and SWs. It is important to note that only half of our respondents reported that ethics resources were available in their organization. Of those, respondents with ethics education,

especially continuing ethics education, were more likely to use available resources and find them useful than those without ethics training—who were more likely not to use available ethics resources. A 2005 report of the Royal College of Physicians (London, England) stressed that clinicians should have access to around the clock ethical advice (Mayor 2005).[15] Advice and resources can only be useful, however, if they are used. Ethics education, especially that provided through in-service or continuing education influences not only the use of ethics services, but also the reasons that nurses and SWs choose not to use them.

SWs have more education overall, have more ethics related education and training, more confidence in their moral judgments, higher moral action scores, more frequently use ethics resources and find them more useful than their nursing colleagues. Many more SWs have master's degrees than nurses, which may contribute to their reported confidence. Additionally, SWs work independently and in the community more often than nurses, whereas a larger percentage of nurses work in the complex environment of an acute care hospital. Yet, despite the fact that nurses were more likely to have ethics resources available to them, they were less likely to use them and less likely to find them useful. Again, ethics education made a difference.

A call for more ethics education for nurses and SWs encounters many important and unresolved controversies regarding the content and structure of ethics education. What should be taught in an educational course or in-service on ethics? How should competing epistemologies, theories, and applications in ethics be accounted for? There is little consensus on the appropriate content of ethics education or in-service training for practicing healthcare professionals, with some arguing that teaching abstract theories is less meaningful than teaching more skills-based approaches to solving common ethical issues in practice (Allmark 1995; Snider 2001; Lachman 2006; Foster 1993;Aveyard et al. 2005). Similarly, there is some disagreement over whether programs that address major topics in bioethics are more or less useful than those that recognize and address the every day moral concerns of these practitioners. An additional controversy surrounds whether it is preferable for nurses and SWs to be taught ethics emphasizing the particular issues and strategies that face members of their own profession or to bring students from a variety of healthcare disciplines together to learn about healthcare ethics and the resolution of ethical problems from an interdisciplinary perspective (Lachman 2006; Foster 1993;Aveyard et al. 2005; Elder 2003). Lack of agreement about content and context is reflected in the way ethics education is offered. Some professional programs offer students independent courses in ethics, some direct students to courses offered through other academic departments, some integrate threads of ethics and other important content throughout a curriculum. In some cases, a continuing education program is dedicated to ethics, in others ethical issues are one small component of a larger program on a clinical topic. No systematic evaluation has been done to determine which educational programs or methods better prepare practitioners to deal with the ethical issues they will predictably encounter. In addition to questions of curriculum and methods, many schools devoted to teaching nurses and SWs are currently facing actual or impending shortages of faculty qualified to teach ethics, among other subjects (Deyoung et al. 2002; Feldman 2001).

Our study has several limitations. First, our response rate was not as high as we would have liked, however, the relatively large sample of respondents represents the education and experiences of nurses and SWs from a range of states in different regions. Secondly, the survey asked for self-reporting of confidence, moral action, ethics education, and use of resources and does not include a study of actual behaviors.

Nurses and SWs are the heart of healthcare practice. When nurses and SWs are hampered in their ability to do what they think is right because of a lack of training, constraints on their confidence, or limited access to needed support services, both the function of healthcare organizations and the quality of patient care can suffer. Ethics education and training through

both professional educational programs and especially through continuing education programs are vital to supplying SWs and nurses with the tools they need to confidently and knowledgably face the many ethical challenges inherent in their work. Ethics resources that are appropriate to their needs and accessible to them in all relevant ways are also necessary to help and support nurses and SWs as they work through difficult ethical issues with confidence and skill.

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Table 1

Sample Characteristics

	Registered Nurses (n = 422)	Social Workers (n = 793)	Total Sample (n = 1,215)
Gender*			
Female	95.1%	80.2%	85.3%
Male	4.9%	19.8%	14.7%
Age			
Mean (Std Dev)	45.9 (10.87)	45.9 (11.02)	45.9 (10.96)
Ethnic Background			
White Caucasian	84.1%	82.9%	83.3%
Black/African American	6.9%	9.1%	8.3%
Asian	4.9%	2.2%	3.1%
Other	4.1%	5.8%	5.2%
Highest Level of Education*			
Diploma in Nursing	15.1%	0%	5.2%
Associate Degree	28.8%	0.1%	10.0%
Bachelor's Degree	37.8%	16.6%	23.9%
Master's Degree	17.1%	79.3%	57.1%
Doctoral Degree	1.2%	4.0%	3.0%
Mean Years in Practice (SD)	19.8 (11.63)	15.6 (9.74)	17.1 (10.62)
Percent employed full time	67.2%	75.1%	71.7%
Current Work Setting*			
Acute care hospital	48.6%	10.5%	24.2%
Specialty hospital	5.8%	8.0%	7.2%
Subacute/Long-term care	6.8%	7.0%	6.9%
Home/Community care	8.2%	17.4%	14.1%
Ambulatory	11.8%	5.3%	7.6%
School setting	1.7%	5.5%	18.8%
Self-employed	0.7%	11.5%	7.6%
Family service	0.2%	12.8%	8.3%
Mental health service	0%	15.5%	10.0%
Nonclinical	3.1%	1.8%	2.3%
Other	13.0%	4.6%	7.6%

*Significant difference between registered nurse and social workers.

Table 2

Course Work or Training in Ethics*

Source of Course Work or Training	Registered Nurses (n = 414)	Social Workers (782)	Total (n = 1196)
Basic professional program	178 (43.0%)	365 (46.7%)	543 (45.4%)
Advanced professional program	54 (13.0%)	212 (27.1%)	266 (22.2%)
Basic and/or advanced professional program	212 (51.2%)	471 (60.2%)	683 (57.1%)
Fellowship training	—	9 (1.2%)	9 (0.8%)
Continuing education	109 (26.3%)	461 (59.0%)	570 (47.7%)
In-house training	118 (28.5%)	265 (33.9%)	383 (32.0%)
No ethics training	94 (22.7%)	59 (7.5%)	171 (14.3%)

* Respondents could indicate more than one source; percentages will not add to 100; 19 people (8 registered nurses and 11 social workers) did not respond to this question.

Table 3

Reasons for Not Using Ethics Consultation Services More Often by Ethics Education for Those with an Ethics Consultation Service/Committee Available (n = 602)

Reason indicated	Source of Ethics Education			
	None	Professional Program Only	Continuing Education or In-House Only	Both Professional Program and Continuing Education/In-House
I am not qualified.*	5.6%	3.5%	1.2%	0
Fear of retaliation	6.9%	8.3%	7.0%	9.1%
Lack of authority	11.1%	10.4%	10.5%	8.2%
Difficult to access	20.8%	19.4%	15.7%	18.3%
Don't feel service is useful	12.5%	11.8%	12.8%	13.9%

* Responses vary significantly by source of ethics education (Chi-square = 11.93, df = 3, p = .008).

Table 4

Comparison of Social Workers and Nurses Who Indicated Their Organization has Available Ethics Consultation Services on Selected Variables*

	Social Workers	Registered Nurses
Ethics Education		
No training	4.5%	20.1%
Professional program only	17.9%	30.9%
Continuing education or in-house training only	31.8%	25.7%
Both professional program and continuing education /in-house training	45.8%	23.3%
Frequency of Seeking Guidance from Ethics Consultation Service or Institutional Ethics Committee*		
Never	30.5%	39.4%
Rarely	34.8%	39.1%
Sometimes	26.2%	17.6%
Often	5.6%	2.4%
Routinely	3.0%	1.4%
Perceived Usefulness of Ethics Consultation Services		
Not useful	7.0%	7.0%
Rarely useful	12.5%	13.6%
Sometimes useful	24.6%	30.0%
Often useful	35.3%	35.0%
Extremely useful	20.6%	14.4%
Confidence Mean (SD)	11.9 (1.72)	11.3 (1.95)
Moral Action Mean (SD)	41.0 (8.01)	38.4 (7.82)

* Only those respondents who indicated their organization/hospital had an ethics consultation service or ethics committee (n = 309 social workers; n = 293 registered nurses).

Table 5

Results of Hierarchical Multiple Regression of Moral Action on Selected Variables

Blocks	Final Unstandardized Regression Weight (Standard error)	Final Standardized (β) Regression Weight	t-Test With Level of Significance
Block 1 (R^2= .070, p < .001)			
Age	0.35 (0.04)	0.04	0.82, p = .414
Female gender	2.80 (0.92)	0.12	3.03, p = .003
Master's education	2.71 (0.80)	0.17	3.38, p = .001
Block 2 (R^2 change = .002, p = .750)			
Social worker	0.51 (0.87)	0.03	0.58, p = .560
Hospital work setting	−0.42 (0.65)	−0.03	−0.64, p = .520
Years in practice	−0.26 (0.35)	−0.04	−0.75, p = .453
Block 3 (R^2 change = .018, p = .022)			
Ethics education in:*	0.71 (1.11)	0.04	0.64, p = .526
Professional program only	1.63 (1.11)	0.09	1.46, p = .145
Continuing education/In-House only Both	1.25 (1.10)	0.07	1.14, p = .257
Block 4 (R^2 change = .196, p < .001)			
Frequency of resource use	1.78 (0.38)	0.20	4.68, p < .001
Perceived usefulness	2.56 (0.34)	0.32	7.43, p < .001
Block 5 (R^2 change = .015, p = .001)			
Confidence	0.58 (0.18)	0.13	3.24, p = .001

* No ethics education served as reference group. Final R^2 = .301 (adj. R^2 = .284)