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ABSTRACT

The final report of a 3-year project which involved the development, implementation, and evaluation of Multi-Course Sequential Learning, a model for integrating ethics education into the curriculum of the undergraduate programs in nursing at the University of Minnesota (UM) in Minneapolis is provided. The project focused on nursing students (n=308) and faculty and teaching assistants (n=40-to-50) at the university as well as nurse educators concerned with ethics education across the country. The program aimed to provide students with the knowledge base in ethics needed for the ethical practice of nursing by developing a coherent sequence of learning experiences delivered via ethics units in existing courses throughout the curriculum. For faculty the aim was to enhance their ability to use the rich examples inherent in students' clinical experiences to help students apply ethical knowledge. The ethics instruction was provided in eight didactic courses and five clinical courses. Faculty development activities included workshops and individual or small group consultation. The project continues past grant funding with the support of faculty and administration at UM. Measures of student improvement found that significant gains occurred. Anecdotal student attitudes indicated that some were positive while others viewed the ethics units as extra work. Faculty participants in workshops were also positive. An executive summary is included. Appendixes contain five reprinted journal articles, the curriculum, information on a handbook, and student achievement data. (JB)

ETHICS EDUCATION FOR BACCALAUREATE NURSING STUDENTS

University of Minnesota
School of Nursing
6101 Unit F
308 Harvard Street SE
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Grant Number: G008730488

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Grant Award:	Year I	$54,470
	Year II	64,322
	Year III	75,584
	Dissemination Grant:	11,595
	Total	$205,971

Multi-Course Sequential Learning (MCSL) is a strategy used to provide ethics education to baccalaureate nursing students at the University of Minnesota School of Nursing. The Ethics MCSL, the equivalent of a four credit course, incorporates ethics units into existing required courses in the curriculum. The Ethics MCSL has continued after the end of the grant. Dissemination has been accomplished through: 1) a handbook for nurse educators providing learning materials and teaching strategies; 2) a national conference that brought together nurse educators from 26 states and Canada; and 3) publication of 6 journal articles. A dissemination grant funded ethics education consultation to 10 schools of nursing in the United States and Canada.

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Project reports:

"Ethics Education for Baccalaureate Nursing Students: Project Report, Year I," May 3, 1988.

"Ethics Education for Baccalaureate Nursing Students: Project Report, Year II," May 22, 1989.

Handbook:

Duckett, L., Waithe, M. E., Boyer, M. Schmitz, K., and Ryden, M. B. (Eds.) (1990). MCSL Building: Developing a Strong Ethics Curriculum Using Multi-Course Sequential Learning. Minneapolis: University of Minnesota School of Nursing.

Journal Articles:

Ryden, M. B., Duckett, L., Crisham, P., Caplan, A., & Schmitz, K. (1989). Multi-course sequential learning as a model for content integration: Ethics as a protoype. Journal of Nursing Education, 28(3), 102-106.

Waithe, M. E., Duckett, L., Schmitz, K., Crisham, P., & Ryden, M. B. (1989). Developing case situations for ethics education in nursing. Journal of Nursing Education, 28(4), 175-180.

Ryden, M. B., Waithe, M. E., Crisham, P., Caplan, A., & Duckett, L. (1989). Wrestling with the larger picture: Placing ethical behavior in clinical situations in context. Journal of Nursing Education, 28:(6), 271-275.

Duckett, L., Ryden, M. B., Waithe, M. E., Schmitz, K., Caplan, A., & Crisham, P. (1990). Teaching ethics in professional education. Thought and Action, 6(1), 77-84.

Pederson, C., Duckett, L., Maruyama, G., & Ryden, M. (1990). Using structured controversy to promote ethical decision making. Journal of Nursing Education, 29(4), 150-157.

Duckett, L. Rowan-Boyer, M., Ryden, M. B., Crisham, P., Savik, K., & Rest, J. R. (In press). Challenging misperceptions about nurses' moral reasoning. Nursing Research.

Journal articles are included in Appendix A.

EXECUTIVE SUMMARY
ETHICS EDUCATION FOR BACCALAUREATE NURSING STUDENTS

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A. Project Overview

This three year project involved the design, implementation, and evaluation of Multi-Course Sequential Learning (MCSL), a model for integrating ethics education into the curriculum of the undergraduate program in nursing at the University of Minnesota. A total of 308 nursing students were involved in the project, receiving ethics education in eight didactic courses and five clinical courses. Faculty development activities, including workshops and individual or small group consultation, involved 40-50 faculty and teaching assistants. Dissemination took place through the publication of a handbook of educational materials, six publications, a national conference, workshops for faculty from seven schools of nursing within Minnesota, and consultations to 10 schools of nursing in Texas, South Dakota, and Canada.

B. Purpose

The project focused on three target groups: undergraduate nursing students at the University of Minnesota, faculty in the School of Nursing, and nurse educators across the country who are concerned about ethics education. For nursing students, the purpose was to provide them with the knowledge base in ethics needed for the ethical practice of nursing by developing a coherent, carefully structured sequence of learning experiences delivered via ethics units in existing courses throughout the curriculum. For faculty, the purpose was to enhance their ability to use the rich examples inherent in students' clinical experiences to assist students to apply ethical knowledge to practice. For nurse educators in programs across the country, the purpose was to make available educational materials, teaching strategies and other project outcomes.

C. Background and Origins

We identified both a local and a national need for ethics education for students in baccalaureate nursing programs. Advances in technology and the growing complexity of the health care delivery system present today's nurses with numerous ethical issues. Faculty and students at the University of Minnesota recognized that ethics education in the undergraduate nursing program was inadequate. The administration and the faculty responsible for the undergraduate curriculum approved the Ethics MCSL as an approach to providing this content for students prior to submission of the grant. The University of Minnesota provided a rich context for this project, with multiple resources available to the project staff, students, and faculty.

D. Project Description

The content domain in nursing ethics was identified, and components were threaded carefully throughout the curriculum via ethics units that were incorporated into eight didactic courses and five clinical courses. The integrity of a traditional course was maintained by having ethics faculty

accountable for: 1) learning objectives for each unit; 2) teaching strategies to enable students to achieve the learning objectives; and 3) evaluation of learning in the Ethics MCSL. Midway through the project, a revised, upper division curriculum was implemented, with the Ethics MCSL as an integral component. Workshops for faculty held in years 01 and 02, and close working relationships between project faculty and faculty teaching each of the courses containing an ethics unit made it possible to achieve both student learning objectives and faculty development objectives. Publication of articles describing the model and depicting specific educational strategies developed as part of the project have contributed to meeting the national need related to ethics education. The 145 participants from across the U.S. and Canada who attended the national conference in year 03 each received a copy of the handbook that contains educational materials for more than 20 specific learning activities for the teaching of ethics. The post-project dissemination grant made it possible for faculty at 10 schools of nursing in South Dakota, Texas, and Alberta, Canada to benefit from consultation and workshops by project faculty.

E. Project Results

The Ethics MCSL continues now that grant funding has ended, with support from both administration and other faculty. Evaluation of student learning was carried out by project staff through examinations (essay and multiple choice), term papers, case analyses, and presentations of group projects. Other faculty who incorporated ethical components into work sheets or clinical care plans also evaluated learning in ethics. Students' progress in moral reasoning was assessed using the Defining Issues Test at entry and exit to the program. Significant gains occurred for three of the four subgroups tested. Attempts to obtain student self-evaluations of ethics learning were disappointing. Anecdotal information suggests some students viewed the Ethics MCSL very positively and sought out project staff for further assistance; some students, while acknowledging the importance of ethics education, voiced a preference for a discrete course, and viewed the MCSL as "extra work" in an already stress-filled program.

The effect on of the project on faculty was positive as indicated by their evaluations of two workshops and by a summative evaluation of the project completed at the end of the funding period. Evaluations by persons attending the national conference reflected the very positive impact the program had on participants. Similarly, the workshops presented as part of the consultation visits were evaluated highly by faculty in the ten schools involved. Interest in the handbook is reflected by requests for copies following distribution at the national conference. Another outcome of dissemination activities is the implementation of the model of an Ethics MCSL in a consortium of six schools of nursing in Alberta, Canada.

F. Summary and Conclusions

This project was successful in accomplishing the stated purposes put forward in the initial proposal with respect to the student target group as well as the faculty in the School of Nursing and selected nurse educators across the country. Additional data collected during the project regarding relationships among such variables as measures of intellectual ability, achievement in the MCSL, clinical performance ratings, and moral reasoning scores are still being analyzed. There are data to substantiate our belief that support from the Fund for the Improvement of Postsecondary Education has done just that--improved the education of nurses for ethical practice, not only on the local level here in Minnesota, but at the national and international level of postsecondary education. However, the social significance of this project may not be known for some time.

FINAL REPORT

Project Overview

This three year project involved the design, implementation, and evaluation of a model for integrating ethics education in the curriculum of the undergraduate program in nursing at the University of Minnesota. The model, Multi-Course Sequential Learning (MCSL), is an approach in which a vertical course extends throughout the program with units embedded in required courses. This integrative approach builds on students' growing knowledge and skill in nursing as well as their intellectual development and is consistent with the conception of the developmental nature of moral reasoning. A total of 308 nursing students were involved in the project, receiving ethics education in eight didactic courses and five clinical courses.

A major outcome of this project is the establishment of a means of ethics education, the Ethics MCSL, that continues beyond the period of grant support to provide students with a coherent body of knowledge in ethics. The MCSL encourages students' sensitivity to ethical concerns, gives them practice in critically reasoning about moral problems, promotes caring and a commitment to act on what they believe to be right, and assists them in developing skills essential to taking moral action. Evaluation of learning in ethics units was carried out by a variety of approaches. Pre- and post-test scores on a measure of moral reasoning, the Defining Issues Test (DIT), show significant progression in moral reasoning from entry to exit from the program.

Faculty development in the area of ethics was made possible through two workshops and on-going consultation with project staff as ethics units were incorporated into existing courses. Evaluations by faculty of the effect of the project on their teaching and their practice were highly positive. Faculty perceived that the project positively affected students' moral sensitivity, reasoning, commitment, and action.

Educational materials developed for use in the Ethics MCSL have been disseminated through journal articles and through the publication of a handbook. Workshops were given to develop faculty expertise in ethics at seven schools of nursing within the state. A national conference, "The Care-Justice Puzzle: Education for Ethical Nursing Practice," was positively evaluated by participants from 26 states and Canada. Consultations funded by a dissemination grant included 4 workshops involving over 200 participants at 10 schools of nursing.

Purpose

The purposes of the original three year project were:

1) to plan, implement, and evaluate a major curricular change in the Undergraduate Nursing Program at the University of Minnesota, so that learning experiences related to ethical principles, theories, and codes that provide the foundation for ethical conduct by professional nurses systematicially occur throughout the program;

2) to refine a model, Ethics Multi-Course Sequential Learning or MCSL), that can be used by other colleges of nursing for including ethics in undergraduate nursing curricula;

3) to develop educational materials and teaching-learning strategies for local and national use;

4) to enhance the ability of faculty colleagues to use the rich examples inherent in students' clinical experiences to assist students in using concepts and principles that apply to ethical conduct in nursing;

5) to disseminate information about the model, teaching-learning strategies and materials, and project outcomes to nursing educators throughout the country via a national conference, a manual, journal publications, and presentations.

In addition, the purpose of the dissemination grant, which we received at the conclusion of the project, was to provide consultation services to a minimum of four schools of nursing to assist the schools in developing a program of ethics education suitable for the needs of the students and faculty

of the individual schools.

This overall statement of purposes served us well throughout the project, giving direction to our activities each year. Early in the project we discovered that we needed a conceptual framework to help us determine how to organize the content domain and our teaching strategies as students progress from being neophytes at entry into the nursing program to seniors ready to begin professional practice. We recognized that we wanted more for our students than we had described in our first purpose. Our ultimate purpose in conducting this project was to promote ethical nursing practice, and thus have a positive effect on individuals, families and groups who receive health care. To accomplish that ultimate purpose, students needed more than the ability to reason about ethical principles, theories, and codes. We found that Rest's model of moral action (Rest, 1986) was valuable for both students and faculty. Rest described four components, all of which contribute to ethical behavior: moral sensitivity, moral reasoning, moral commitment, and moral action. Although the components are interactive, not linear, we thought that the place to start with novices in nursing was to raise awareness of everyday moral problems nurses face and develop the ability to use a body of knowledge in ethics to reason about what a morally defensible position would be. As students progressed through the program, it was our goal for them to recognize how competing values might affect a person's commitment to act, and to develop skills in effectively taking moral action.

Background and Origins

We identified both a local and a national need for ethics education for students in baccalaureate nursing programs. Advances in technology and the growing complexity of the health care delivery system present today's nurses with numerous ethical issues. A national survey of nursing programs reported in the literature (Aroskar, 1977) revealed serious deficiencies in the teaching of ethics. Nurse educators are faced with an explosion of knowledge, with curricula bursting at the seams because of attempts to provide students with all they need to know to practice nursing

safely and effectively. Adding the additional requirement of a course in ethics is problematic for many schools. Yet, there is evidence that attempts to integrate ethics have led to gaps and duplication of content (Dison, 1985, p. 2).

Faculty and students at the University of Minnesota recognized that ethics education in the undergraduate nursing program was inadequate. The administration and the faculty responsible for the undergraduate curriculum approved the Ethics MCSL as an approach to providing this content for students prior to submission of the grant. This project made it possible to test the feasibility of this approach.

A MCSL shares characteristics of traditional courses in that 1) a content domain has been identified with learning objectives for students clearly stated; 2) an identified faculty person(s) is accountable for organizing learning activities to enable students to achieve the objectives; and 3) student learning is evaluated and feedback is provided to students about their achievement of the objectives. The careful structuring of progressive learning experiences over the course of the program enables students to build on prior learning and minimizes gaps and overlaps of content. The Ethics MCSL, which spreads the content throughout the curriculum via discrete units in existing didactic courses and ethics-focused clinical conferences in practica, potentially offers advantages over a traditional course, offered at one point in time. The content can be designed to meet the needs of the learners as they grow professionally throughout the program. Novices struggling to understand a professional role require an introduction to ethics, but they are not in a position to grapple with issues in the way students can as they experience clinical realities. The MCSL enables faculty to help students use a body of knowledge about ethics as they struggle with concerns about aggressive versus limited treatment when they are in critical care, and as they examine social justice issues when they are working with the homeless.

The University of Minnesota provided a rich context for this project. In the School of

Nursing graduate program, the area of moral and ethical issues is one of the central thrusts, with this being the focus of one of the core courses required for all graduate students. Dr. Patricia Crisham, who teaches this content to graduate students, had 5% effort devoted to this project. She participated in planning and did some of the teaching. Another rich resource is the University Center for Biomedical Ethics, directed by Dr. Arthur Caplan. His experience with ethics education for many health care disciplines, and his past work as Associate Director of the Hastings Center, was extremely valuable to the project, as was his dynamic style of teaching. Students were extremely enthusiastic about his contributions to the MCSL, and the visibility of the Center's activities reinforced the importance of ethics in health care. The Center, which sponsored frequent noon hour seminars, also was a valuable resource for meeting our faculty development goal. Yet another campus asset is the Center for Moral Development headed by Dr. James Rest, who served as a consultant to the project, assisting us in applying his model of moral action and in evaluating students' progress in moral reasoning using his instrument, the Defining Issues Test (DIT). All three of these resource persons presented at the national conference, and co-authored project publications. Another stimulating and informative campus organization is an All-University Ethics Interest Group that provided us with an opportunity to interact with faculty across disciplines who are involved in ethics education.

In the midst of the project, a change was made from an undergraduate nursing program that spanned sophomore to senior years to an upper division program. This potentially could have been a formidable obstacle, but the faculty again approved the inclusion of the Ethics MCSL as an integral part of the revised curriculum. The support of the Dean of the School of Nursing and the Associate Dean for Academic Affairs was important throughout the project, and has continued after grant funding ended as they have allocated responsibility for ethics teaching as part of our work load.

Project Description

Student Education Activities: During the initial three years of this project, 308 nursing students were involved in the Ethics MCSL. Since completion of the project, an additional 174 students have received ethics education. Ethics units have been incorporated into eight didactic courses and five clinical courses. Content that previous to the grant had been an essential part of other courses, but not necessarily acknowedged as "ethics," is considered to "augment" the Ethics MCSL. This content has been highlighted, so that both faculty and students become aware of its significance to ethical nursing practice. Appendix B shows the areas of ethics content addressed in the units in specific didactic courses and in clinical conferences.

Development of Educational Materials: We developed numerous strategies for the teaching of ethics and educational materials for faculty and students. Some of these strategies were described in the project publications (see Appendix A). Many of these materials for ethics education were compiled in a handbook, MCSL Building: Developing a Strong Ethics Curriculum Using Multi-Course Sequential Learning, which was distributed to all 145 participants at the national conference, and subsequently by request to 20 individuals and/or schools of nursing. This handbook includes more than 20 teaching and evaluation strategies, handout materials for students, and references for audiovisual and text resources. (See Appendix C for the Table of Contents.)

Faculty Development Activities: The involvement of other faculty in the Ethics MCSL was a primary goal, and was critical to the project. Providing workshops for our faculty years 01 and 02 enhanced their knowledge base in ethics and kept them aware of what their students were doing in the Ethics MCSL. This was important not only to decrease the threat that students might be more knowledgeable than faculty in this area, but also was instrumental in involving faculty in reinforcing student learning in ethics. In year 01, 41 persons attended the workshop, "When Teaching Ethics is Everyone's Responsibility." Participants included 22 of 25 undergraduate faculty, 10 graduate

faculty, 1 faculty from the School of Public Health, 5 graduate teaching assistants, and 3 other graduate students in nursing. In year 02, 26 persons (24 faculty and 2 teaching assistants) were in attendance at the workshop entitled, "When Teaching Ethics is Everyone's Responsibility - Preparing for Life After FIPSE Funding."

Consultation with faculty occurred as we jointly worked with individuals and teams teaching each of the courses. Negotiating the timing of core classes as well as clinical conferences, incorporating ethics sections into existing course papers, and care plans, and including ethics items in examinations were essential to accomplish true integration of the Ethics MCSL into these ongoing classes. We also provided individual consultation for a number of faculty members related to ethical issues they were confronting in their teaching.

Dissemination: The impact of the project beyond our local setting was made possible by the publication of six articles (see Appendix A), and the handbook described above. Workshops were held for faculty in other nursing programs throughout the state, including the Itasca Consortium, which involved 36 nurse educators from 6 schools of nursing in northern Minnesota, and Bethel College in St. Paul, where 10 faculty attended. A national conference, "The Care-Justice Puzzle: Education for Ethical Nursing Practice," held October 16-17, 1990 attracted 145 participants from 26 states and Canada.

Further extension of our work was made possible by the dissemination grant, which allowed schools to obtain ethics education consultation with FIPSE funds paying for 2/3 the cost of the visit and the schools involved paying for 1/3 the cost. Ten schools of nursing, two in South Dakota, two in Texas, and six in Alberta, Canada, participated in the consultation visits. Workshops at these schools were attended by over 200 persons.

Problems We Encountered: Although support for ethics education existed among students and faculty, we experienced some resistance to the Ethics MCSL. Some students expressed a

preference for a traditional course. Some disliked the episodic nature of ethics units. Some resented the responsibility for having to draw on resource material they had received in earlier courses. Some resented that they were truly held accountable for meeting the ethics objectives in evaluations that contributed to their course grade. Students in this nursing program are under great pressure with heavy course work and long clinical hours. At times, some students told us, ethics seemed like something "extra" added on, although they were quick to emphasize that they realized its importance, and wanted ethics content in their program. They did not realize that something had been deleted from the courses to make room for ethics content. Initially, we had wanted the Ethics MCSL to have high visibility so students would be aware that they had taken the equivalent of an ethics course. However, we learned very quickly to use strategies to diminish the appearance of an "add-on" and make the integration less visible. One factor contributing to student response may have been the attitude of some faculty who viewed ethics as belonging to us, the ethics faculty, rather than being a shared concern of all nursing faculty. This perception may have highlighted the "add-on" perspective rather than the view of ethics as an integral aspect of their course. The original "carving out" of dedicated time for an ethics unit in existing courses was possible only because a majority of faculty valued this content enough to make room for it. Objectives related to ethics were an integral part of the overall course objectives, but we found that holding on to the time allocated for the ethics units required ongoing effort by the ethics faculty. The composition of the faculty group changed over the years of the project, and some faculty were concerned that time for ethics education was competing with time needed for other areas of knowledge. We found that flexibility and sensitivity, persuasiveness and assertiveness, accountability and dependability were essential in negotiating issues such as timing of classes and clinical conferences, assignment of readings, and evaluation of student learning.

We have come to appreciate the importance of administrative support that makes the Ethics

MCSL an acknowledged part of our workload. Although this has not been a problem for us, in our consultation in Alberta, this issue of administrative support was critical to the faculty group who had developed their version of an Ethics MCSL. Coming together from six different programs, they had received administrative support to plan the Ethics MCSL in their new collaborative curriculum, which was about to be implemented in the upcoming quarter. However, the ethics faculty were concerned because time for ongoing meetings for them to plan and coordinate was not scheduled. In our meeting with the administrators of the six programs, we emphasized the significance of the support they had already provided and the importance of continued interaction among the ethics faculty. The administrators decided to provide financial support to enable the group to continue to meet.

Satisfactions We Experienced: This project has been a rich vehicle for personal growth. The grant brought together a group of knowledgeable, committed people, and the results described below attest to the productive working relationships that developed among project staff. Our expertise as educators increased as we had an opportunity to develop and use many different active learning strategies with students. Interactions with students were a rich source of satisfaction, as they sought us out to discuss wrenching ethical questions they were facing in their clinical experiences, the classroom, or in their personal lives. Going to other campuses and learning what others are doing, as well as sharing our experiences with them were stimulating and enlightening. Finally, the achievement of the grant outcomes described in the next section was professionally and personally rewarding.

Project Results

Project results will be discussed in terms of the desired outcomes that were outlined in the original grant proposal, and in terms of other indicators.

Outcomes to Be Achieved During the Funding Period

Three categories of desired outcomes were developed to be achieved during the funding

period: student, faculty, and dissemination.

Desired Student Outcomes. Students will: 1) gain knowledge of ethical principles, theories, and codes that provide the foundation for ethical conduct by professional nurses and apply these in clinical practice; 2) become more aware of the nature and complexity of ethical issues in nursing; 3) recognize the independent responsibility of the nurse with respect to ethical concerns in practice; 4) indicate that they feel more prepared to deal with nursing problems that have an ethical component; 5) gain knowledge of resources available to help professionals, such as ethics committees, organizations, and media resources; and 6) progress in moral reasoning toward more principled reasoning.

Evaluation of Student Outcomes. From the beginning of the project to present, student learning of material covered in Ethics MCSL units in core courses has been evaluated in a variety of ways. These include: take-home essay examination questions in two courses in which students learn about ethical principles and theories; ethics multiple choice questions included in exams in two courses; an ethics section of a term paper about a chronic health condition; a written small group analysis of a management case involving chemical abuse by a nurse for the leadership-management course; and a graded group presentation that includes an ethics component for a professional issues course. All of these methods have helped us to assess student achievement of outcome 1 above, and most of these evaluation methods have provided evidence of the extent to which students are achieving outcomes 2, 3, and 5.

Most of the grading of ethics materials has been done by the Ethics MCSL faculty. The exception is the "ethics" section most of the clinical teaching teams have added to the care plans or journals students are required to do in conjunction with working with clients in clinical settings. These sections are included to help students achieve outcome 2 above and the faculty member teaching the student clinically provides feedback regarding the ethics material included in care plans and journals.

During the initial three year funding period, grading of all other ethics materials was done by project staff. Because of the funding, it was possible to develop carefully the methods of evaluation and to increase our skill in evaluating student open-ended responses. Initially, student papers usually were graded by two persons, and a third person was asked for an opinion when there was a large discrepancy between the first two graders. As a result, we feel fairly confident of the fairness of our grading now that the funding has ended and Drs. Ryden and Duckett do all of the Ethics MCSL grading that was previously done with the help staff hired to assist with the project.

For each of the graded materials described above, the majority of students have earned grades in the 80 - 100% range, a minority earned grades in the 70 - 79% range, and a very few earned lower than "C" grades. From the beginning of the project to present, students have been given extensive feedback about their performance on specific evaluation tasks. For example, comments are written on papers and/or students are given feedback about the characteristics of an excellent response and/or students are given a written handout that describes the points one should consider in doing a thorough analysis of the stimulus case. We have tried to use evaluation methods as both means of assessing student learning and as means of stimulating further learning.

During the 3-year initial funding period, two evaluative methods were used at the end of each year to examine how well students were achieving outcomes 1 through 5 above. First, students received a very detailed report of their achievement in the Ethics MCSL at the end of each academic year. An example of a report is included in Appendix D. In addition to being very informative for the students, the data used to produce these reports also were used for other project evaluation purposes. That helped justify the time expenditure during the funding period. However, it was not possible to continue the time-consuming steps that were necessary to produce these reports without the project assistant that the funding provided.

The second evaluative method employed annually was a student evaluation measure that was

derived from the desired student outcomes and the Ethics MCSL unit objectives. This was distributed to students at the end of each year. Unfortunately, the return rate for these questionnaires was too low for results to be meaningful. The low return rate appeared to be due to the fact that no time was allocated for in-class completion. For the first two years, the evaluations were distributed a second time, in a mailing to students' homes along with the end of year grade reports. Because of the lack of success of this approach to getting student evaluations, we are currently attempting to get the evaluation of the Ethics MCSL units incorporated into the regular course evaluations. This is not a simple task since course evaluations vary considerably from course to course, both in format and in procedures used for obtaining data. Anecdotal information suggests some students viewed the Ethics MCSL very positively and sought out project staff for further assistance. As described earlier, some students, while acknowledging the importance of ethics education, voiced a preference for a discrete course, and viewed the MCSL as "extra work" in an already stress-filled program.

In order to assess student achievement of outcome 6, students who participated in the Ethics MCSL during the original funding period were pre- and post-tested using the Defining Issues Test (DIT) (Rest, 1979, etc.) Student pre- and post-test DIT means and standard deviations are shown in Table 1. Prior to receiving the three-year funding, in an effort to have a comparison group, we pre-tested the last class of students who entered the program before the Ethics MCSL was initiated. This class is the first group whose scores are shown in the table.

For the total group of students for whom there is longitudinal data, and for three of the four subgroups, significant gains occurred in DIT scores between entry and exit tests. It is not possible, given the design of the evaluation, to determine whether the significant changes in DIT P% mean scores should be attributed to additional experiences in college, to the undergraduate nursing curriculum in general, to the ethics curriculum, or to a combination of all three. Rest (1979, pp.

Table 1
Defining Issues Test (DIT) P Percent Scores: Longitudinal Data from Four Groups of Basic[a] Baccalaureate Nursing Students

Entry Test Date	Spring 1987		Fall 1987		Winter 1988		Fall 1989		All Dates	
Sample Subgroups[b]	A	B	A	B	A	B	A	B	A	B
Entry DIT P% $\bar{x}$	40.6	45.0	46.6	44.8	41.8	50.5	43.4	38.8	43.3	43.5
Entry DIT P% sd	14.7	17.3	13.9	15.4	12.2	9.3	13.8	13.1	13.7	14.0
Entry DIT P% range	12-67	12-72	20-72	25-68	17-62	38-63	13-75	20-57	12-75	12-72
Exit DIT P% $\bar{x}$	48.1		53.2		43.7		51.1		49.5	
Exit DIT P% sd	15.2		16.6		12.7		12.9		14.5	
Exit DIT P% range	13-75		17-87		25-70		22-77		13-87	
n[c]	26	2 + 6	32	3 + 4	27	2 + 6	48	10 + 8	133	41
t-test[d]	4.31		4.08		.84		4.42		6.6	
df	25		31		26		47		132	
p value	.0002		.0003		.41		.0001		< .0001	
$\bar{x}$ credits[e]	67	45	141.9	132.7	69	63.5	126.1	123.5	96	84.6
sd credits	35.2	1.7	53.1	31.3	16	21.1	54.7	33.2	52.8	43.4

[a]Basic students are students who are not registered nurses when they enter the baccalaureate program.

[b]The "A" column contains data from students with a valid entry test score who also have a valid exit test score. The "B" column contains data from students with a valid entry test score who do not have a valid exit test score, were not posttested, or have not graduated. Columns A & B combined contain data from the same students, at each time period, as those reported in Table 3.

[c]The number reported in column "A" is the number of students with a valid entry P% score who also had a valid exit P% score. The first number in column "B" is the number of students with a valid entry P% score but with an invalid exit P% score. The second number in column "B" is the number of students who left the program prior to completing an exit DIT. The n from column "A" plus the total n from column "B", for each time period, equals the n with valid scores for each time period on Table 3.

[d]Comparison of entry mean P% scores with exit mean P% scores using a paired t-test.

[e]Credits reported are total number of college credits completed by entry into the nursing program for those with valid DIT scores.

113-119) presented evidence that intellectual milieu is associated with moral judgment, and suggested that moral judgment differences may be interpreted in terms of enriched versus impoverished environments. The Ethics MCSL and, to some degree, the previous nursing curriculum included learning activities that have been suggested as experiences that foster moral development (Rest 1979, p. 222). Nursing students who experienced the Ethics MCSL were exposed to ethics content *and* encouraged to examine their views and allow their perspective to be challenged by others. According to Rest (1979, p. 116), this process leads to more complex and advanced thinking, that is, higher principled reasoning scores.

It is important to note that, although the first group pre- and post-tested completed the nursing program in Spring 1989 without participating in the Ethics MCSL, they were being taught by faculty who attended two full-day ethics workshops (Spring 1988 and Spring 1989) before they graduated. Faculty members may have started to incorporate more ethics into their clinical and classroom teaching without realizing it. The one group of students who did not show significant change from entry to exit DIT testing (Table 1, group pre-tested Winter 1988) is an interesting, and somewhat atypical group. They had next to the lowest entry mean DIT P% score, and the lowest exit mean score. This group was the last to be admitted as sophomores prior to the implementation of the undergraduate program curriculum revision. They were admitted at a time when the number of applicants to the program had reached the lowest point in many years. There were eight students in the entry group who had valid pre-tests, but were lost to longitudinal followup, six of whom left the program, and two of whom had invalid post-tests. It is noteworthy that the six who left without graduating had a mean entry DIT score of 48.2, which was higher (n.s.) than the 41.8 mean of the total group.

Questions related to associations between DIT scores and other variables of interest will be the focus of additional analyses of the evaluation data that have been collected. A manuscript that is

in progress will report the pre- and post-test DIT scores and relationships between DIT scores and gender, GPA, ACT scores, credits completed prior to entry into the school, clinical performance, and classroom measures of Ethics MCSL achievement.

Desired Faculty Outcomes. The proposal listed the following outcomes for School of Nursing faculty: 1) gain increased awareness of ethical implications of every day experiences in health care settings; 2) increase their knowledge about ethical principles, theories, and codes that provide the foundation for ethical conduct by professional nurses; and 3) gain increased skill in assisting students to apply ethical concepts and principles as the care for specific patients.

Evaluation of Faculty Outcomes. Evaluations by participants at the faculty workshops held in year 01 and year 02 were highly positive. Mean ratings of responses to all the stimulus statements were 5 or greater on a scale of 1-7 (strongly disagree to strongly agree).

Evaluations of the ethics education project were completed by 16 faculty at the end of the funding period. With respect to the extent to which the project affected their own teaching, 87% gave a rating of 4 or greater on a scale of 1-7, with a mean rating of 4.8; 86% rated the project a 4 or greater in terms of the extent to which the project affected their own nursing practice (mean = 4.5). When asked about their perception of the time allocation for ethics within courses in the curriculum, 1 person thought it was inadequate, 11 indicated it was appropriate, and 4 considered it to be excessive.

Faculty were asked to what extent the project had an impact on students in terms of their ethical sensitivity, their moral reasoning, their commitment to moral action, and their ethical action. Mean ratings on a 7 point scale were: sensitivity, 5.8; reasoning, 5.3; commitment, 5.1; and action, 4.8.

Dissemination Outcomes. The following were proposed as dissemination outcomes of the project: 1) a handbook to be disseminated to baccalaureate programs across the nation; 2) at least

three manuscripts describing various aspects of the project; 3) presentations regarding curricular innovations and related student outcomes at nursing education and research meetings; and 4) sponsorship of a national ethics education conference.

Evaluation of Dissemination Outcomes. The 200 page handbook, MCSL Building: Developing a Strong Ethics Curriculum in Nursing Using Multi-Course Sequential Learning, contains educational materials for faculty and student handouts for more than 20 learning experiences. (See Appendix C for the Table of Contents.) This handbook was distributed to the 145 participants at the national conference in year 03, and subsequently to 20 additional individuals or schools of nursing by request. The six project-related publications included in Appendix A further disseminated the work of the project to a national audience. Five publications were in nursing journals; one publication in Thought and Action was written for a broader audience of educators in higher education. Focus, a University of Minnesota publication, also carried an article about the project. The following presentations about project were made: 1) "First Annual Nursing Conference on Ethical Issues," George Washington University Hospital; Washington, DC; 2) a meeting of Third District Minnesota Nurses' Association, Minneapolis; 3) the All-University of Minnesota Forum for Ethics in the Curriculum, Minneapolis' 4) the Zeta Chapter of Sigma Theta Tau, the national nursing honorary society, St. Paul; 5) Association for Gerontology in Higher Education, in Tampa, FL; 6) College of St. Benedict, St. Joseph, MN; 7) "Ethics and Nursing Practice: New Dimensions in an Era of Complexity," University of Maryland School of Nursing, Baltimore; and 8) Multidisciplinary Team Approach in Ethical Decision Making Conference, Veterans Administration Medical Center, Beckley, W VA.

The national conference, "The Care-Justice Puzzle: Education for Ethical Nursing Practice," was successful in attracting 145 participants from 26 states and Canada. Mean ratings of the conference by participants were very positive, ranging between 3 and 4 on a scale of 1 - 4 (Poor to

Excellent). Comments included, ".. stimulating, thought-provoking, realistic and most useful."

Purpose of the Dissemination Grant. To further strengthen the national impact of this project, the dissemination grant provided support for consultation services to schools of nursing to assist them in developing a program of ethics education suitable for the needs of the students and faculty of the individual school.

Evaluation of Outcomes of the Dissemination Grant. Workshops were provided for faculty as part of each consultation visit. Evaluations by 23 participants at the Augustana/University of South Dakota two-day workshop, May 20-21, 1991, revealed mean ratings between 4 and 5 on a scale of 1 - 5 (Not Interesting to Very Interesting), and (Not Useful to Very Useful) with the majority rating workshop activities at the 5 level.

During the consultation at the University of Alberta in Edmonton, we gave an evening presentation, "Ethics is an Everyday Occurrence," August 21, 1991, to a nurses' bioethics interest group. Evaluations by 36 participants again showed mean rankings between 4 and 5 using a similar scale. A workshop on August 22, 1991 for 125 faculty from six participating schools of nursing in the province of Alberta elicited completed evaluations from 83 attendees. Mean ratings were between 4 and 5, using the scale described above, for all except one area: "Who Should Teach Ethics?" which was rated 3.79/3.78.

The final consultation visits, to the University of Texas, San Antonio, and the University of Texas, Austin, included a joint faculty workshop in San Antonio on November 7, 1991. Ratings that were completed by 18 of the participants ranged from 3.36 (Who Should Teach?) to 4.44 (Model of Moral Action).

Outcomes to be Achieved Beyond the Funding Period

The outcomes that we believed would occur *following* the initial three year funding period (9/87 - 9/90) include: 1) The ethics MCSL will continue as part of the school's curriculum

indefinitely, with revisions to be made as needed; 2) other schools of nursing will use the MCSL approach to ethics education and the educational materials that are developed as part of the project; 3) the MCSL approach to teaching ethics will be used as a model for integrating other important strands into the nursing curriculum, at the University of Minnesota and in other schools of nursing across the country; and 4) other school of nursing will ask project faculty to serve as consultants.

Progress in Meeting Outcomes to be Achieved Beyond the Funding Period

The Ethics MCSL continues as part of the school's curriculum. The model proved adaptable when the undergraduate curriculum was revised to an upper division major. And now, even at a time of financial cutbacks for the School of Nursing, teaching the Ethics MCSL continues to be acknowledged by administration and faculty as a part of the teaching load for Drs. Duckett and Ryden. We continue to revise previously used ethics teaching materials and to develop new materials. This quarter, a former student who was in the first group who participated in the Ethics MCSL and now works on the bone-marrow transplant unit at University of Minnesota Hospital, collaborated with us to develop a case situation for an ethics-focused clinical conference.

We were instrumental in forming a committee to plan and carry out a systematic evaluation of the revised undergraduate curriculum. Most components of the evaluation of student outcomes used in the Ethics Education Project were included in this curriculum evaluation plan, and some new aspects were added. (See Appendix E.)

The MCSL approach to integration of ethics content into the curriculum is being implemented by the six nursing programs in the Collaborative Curriculum in Alberta, Canada. Articles written by project staff and educational materials developed as part of the project are in the hands of nurse educators at schools of nursing across the country. We have received numerous calls for assistance from others interested in seeking funding to support ethics education projects at their institutions.

Much remains to be done. The grant ended far too soon. We are continuing to analyze data

gathered during the project to explore relationships among factors hypothesized to influence ethical behavior of nurses. We hope to be able to carry out a five year follow-up of students to determine their perceptions of the extent to which the Ethics MCSL prepared them to cope with the problems they face in their practice.

Summary and Conclusions:

Support from FIPSE has made it possible for us to bring a dream to reality. The Ethics MCSL has proven to be a feasible method of providing ethics education. Our data show students have achieved the learning objectives and have made significant progress in moral reasoning. We believe the ethics education they received has provided them with a foundation for ethical practice as they become licensed as registered nurses. This project has strengthened our belief in the importance of producing graduates who are sensitive to ethical issues, skilled in reasoning about the dilemmas they confront, committed to acting on what they believe is right, and possessed of the ego strength and interpersonal skills to take effective moral action. The Ethics MCSL has proved to be an adaptable model. During the course of the project, our own school made a major curricular change, moving from a three year curriculum to a two year, upper division program. Courses changed, but we were able to adapt the ethics units readily to the new format. In our consultation with faculty in ten schools of nursing, we have assisted them in grappling with possible adaptations of an Ethics MCSL to their own programs and have provided ethics workshops to facilitate the development of their faculty.

However, an Ethics MCSL is not the *only* approach, nor is it necessarily the *best* approach in every situation. A carefully constructed sequence of units across courses is not possible in programs where students do not share a common core of classes. A MCSL approach to teaching ethics is not possible unless there is a faculty commitment to make room for ethics within existing courses. There may be faculty and student resistance to MCSL.

Despite these limitations, the promise of the model has been fulfilled in our setting, and is being tried out in at least one other setting, the collaborative curriculum being taught by the consortium in Alberta, Canada. The teaching/learning strategies for ethics units and for clinical conferences that were developed as part of the project have been widely disseminated, and have the potential for adaptation to many different educational settings, within traditional ethics courses or as part of an integrated approach to the teaching of ethics. We have come to see that the ethics education needed by nurses is more than the traditional content of bioethics courses that often are taught by persons with expertise in moral philosophy. Nurses share with other health care disciplines some vexing ethical questions, and there is value in grappling together with other health care providers to find solutions. However, there is a nursing perspective on ethical problems that is different from a medical perspective. It is the application of *both* nursing knowledge and moral knowledge to the situations confronted by nurses that is necessary to ethical practice of nursing.

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APPENDIX A

JOURNAL ARTICLES

Multi-Course Sequential Learning as a Model for Content Integration: Ethics as a Prototype

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ABSTRACT

Multi-course sequential learning (MCSL), a model for integrating content throughout the curriculum, is described using ethics education as a prototype. In this model, content is presented via a vertical course, with units embedded in existing courses across various levels of the nursing program, which is designed to provide coherent organization of content, visibility, and accountability, and to prevent gaps and unnecessary duplication. This article describes the process of developing an Ethics MCSL, which is being implemented and evaluated with support from a three-year grant from the Fund for the Improvement of Postsecondary Education (FIPSE).

Introduction

Since mid-century, most nursing curricula have been changed so that they no longer mimic a medical model based on body systems or on patient care areas, but are integrated structures that have attempted to provide a more holistic, person-centered approach to nursing care (Longway, 1972). The integrated curriculum movement was, according to Redman (1978), a seminal change in nursing education, but it was like a shadow, not fully developed. Today, two primary factors are providing direction for constructing nursing curricula. One factor is the work of nursing theorists (Johnson, 1980; King, 1971; Neuman, 1980; Newman, 1986; Orem, 1980; Rogers, 1980; and Roy, 1984). The second is consensus about the central concepts of the discipline—person, environment, health, and nursing—revealed by reviews of the literature on theory development in nursing (Fawcett, 1984; Flaskerud & Halloran, 1980). Although translating the concept of an integrated curriculum into programs of nursing has led to some laudable outcomes, this process has been problematic for both faculty and students (Styles, 1976). Educators continue to struggle with how to delineate and organize the multiple parts that make up the whole in integrated programs.

As the knowledge basic to nursing increases, educators are challenged to expand curricula which are already bulging at the seams. Adding new courses means increasing the number of nursing credits, and perhaps the length and cost of the program, or alternatively, deleting existing requirements within the major, in the liberal arts, or in supportive courses. Integrating concepts or areas of content which have been identified as being important rather than adding courses has been one approach, exemplified by the incorporation of mental health concepts in nursing programs. However, such integration carries a risk of a scattered, disorganized, incomplete, or duplicative presentation of content. The amount of emphasis on content strands and the quality of the teaching may be dependent on the interest and expertise of the faculty assigned to various courses. "Integrating in" may actually result in "integrating out."

Model Description

An approach to curriculum development that provides a model for weaving an identifiable strand of content throughout a program is Multi-Course Sequential Learning (MCSL). This model, originated by Ryden (1984),

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proposes a vertical course, with units embedded in existing courses across the various levels of the program. A carefully constructed MCSL (pronounced "muscle"), provides a strong content fiber running through the curriculum. Important characteristics of a MCSL include the following: 1) the content domain is precisely identified; 2) content is carefully sequenced from course to course in the various levels of the program so as to provide a good fit with student development and to build on previous learning, while preventing omissions and undesirable duplication; 3) the course is given visibility as an entity; 4) student learning in the MCSL is specifically evaluated, based on achievement of stipulated objectives; and 5) a defined group of faculty is given responsibility and accountability for the MCSL.

Such a model addresses many of the problems inherent in integrating content, including ordering of content in a hierarchical manner (Smith, 1981), avoiding gaps and overlaps (Dison, 1985), dealing with the specialist vs. generalist role of faculty (Styles, 1976; Murdock, 1978), and utilizing a developmental perspective (Smith, 1981). This approach combines the benefits of a discrete course given at one point in time with the advantages of a content strand that provides what is most applicable to students at various stages during their progression through a program.

Steps involved in the process of developing a MCSL are listed in the Table. The discussion which follows illustrates the use of this process in the development of an Ethics MCSL as a prototype.

Development of an Ethics Model

This article is the first in a series describing the implementation of an Ethics MCSL for baccalaureate students at the University of Minnesota. Although courses in moral and ethical positions in nursing were being offered at the graduate level for students in nursing, no coherent approach to the teaching of ethics had been developed for undergraduate students. The need for such an approach was identified by faculty in a workshop that focused on assessment of the undergraduate program. Students have also recognized a need for more content on ethics. An informal survey of 30 senior students revealed that only three had taken any courses or workshops focusing on ethics.

As a first step, the existing curriculum was analyzed carefully to determine precisely what content relevant to ethics was included, and where and how it was presented. The curriculum contained no course in ethics, and there was no requirement for a supportive course from another department. Several nursing courses had among their objectives one that related to ethics. However, these objectives had not been constructed as part of a whole that reflected a comprehensive analysis of the knowledge and skills students need in this area. There had been no systematic organization of content and learning experiences that built from one course or one level to another. This resulted in the students' receiving occasional lectures on topics related to ethics, but there were enormous gaps and occasional duplication in content.

Despite this clear evidence of need for improvement in ethics education, examination of the curriculum revealed that some content relevant to and supportive of ethics was currently being taught, although it was not labeled as "ethics." For example, in communications courses, students were learning how to demonstrate respect for the dignity of their clients, and how to mutually involve clients in goal setting and in choosing alternative means to achieve such goals. In skills courses, students were learning about the importance of providing privacy, giving accurate information, and gaining consent before carrying out any nursing procedures with a client.

The next step in the process of developing an Ethics MCSL was to delineate the content domain. A review of the literature and consultation with faculty who had developed and taught ethics courses in the graduate program in nursing, served as the basis for determining ethics content appropriate to the baccalaureate level. The literature review substantiated the importance of ethics education for nurses, and writings by nurse ethicists and moral philosophers identified serious deficiencies in present programs (Aroskar, 1977; Dison, 1985; Benoleil, 1983; Bindler, 1977; Evers, 1984; Muyskens, 1982; Purtilo & Cassel, 1981; Steinfels, 1977).

It became clear that our local need for improvement in ethics education was a reflection of a national need. The importance of ethics to nursing was formally acknowledged by the American Nurses' Association (1980) when it officially resolved to work on clarifying the ethical issues in nursing practice and to establish a process for nurses to actively participate in ethical decision making. To enable practicing nurses to do this, their baccalaureate education must include preparation for such a role. How best to prepare nursing students for ethical decision making and action is a crucial concern for nurse educators.

In attempting to identify the content domain of ethics for undergraduate nursing students, we found that merely extending the teaching of standard medical ethics to professional nursing students is not appropriate. While the ethical concerns and responsibilities of nurses include areas which overlap with those of physicians, the nursing role provides a different perspective on some shared problems, and also gives rise to some significantly unique problems (Jameton, 1977). Dison's study of the recurring ethical dilemmas experienced by nursing students (1985) and Crisham's explorations of the ethical problems encountered by practicing nurses (1981) revealed the variety and prevalence of ethical issues within nursing. Based on a conception of the domain of ethics in nursing, objectives were developed to depict clearly the outcomes desired for students at the completion of the Ethics MCSL. Content was then organized into units appropriate for inclusion in existing courses and unit objectives were specified.

Content that already was being taught, but not identified as ethics, was cited as "augmenting" the Ethics MCSL. Augmentation is defined as enlarging, extending, or

FIGURE 1

TIME ALLOCATION FOR ETHICS COMPONENTS OF NURSING CLASSES AT EACH LEVEL OF THE CURRICULUM
22 HOURS CORE AND 20 HOURS AUGMENTATION

SOPHOMORE LEVEL	JUNIOR LEVEL	SENIOR LEVEL
Core (To be taught by project staff):		
Introductory course 4 class hours	Theory course 2 class hours Research course 1 class hour	Professional issues course 4 class hours
Clinical course 1 hour clinical conference	Clinical courses:	Clinical courses:
	—Chronic health problems —Loss —Stress & Crisis —Health 1 class hour and 1 hour clinical conference for each course above	—Acute care 1 hour clinical conference —Community health 1 hour clinical conference
Augmentation (To be taught by faculty with assistance from project staff):		
[1]Interpersonal communications course	[1]Advanced interpersonal communications course	[3]Leadership/management course
[2]Nursing skills laboratory	[2]Advanced nursing skills laboratory	[4]Research application course

[1]The values, attitudes, knowledge, and skill in the area of human relationships essential to ethical conduct in interpersonal interactions, and emphasis on genuineness, respect, empathy, rights of clients, eliciting the perspective of others, and congruence in nurse-client goals.
[2]Explaining the purpose of procedures, gaining consent before carrying out nursing activities, and maintaining the dignity and privacy of the individual.
[3]Theory and practice in the areas of decision making, assertiveness, and conflict resolution which develop skills needed to help make ethical decisions and to put decisions made into practice.
[4]Applying of principles relating to informed consent, confidentiality, and rights of human subjects in research.

enhancing. This concept of augmentation led to subsequent activities designed to stimulate faculty development by raising awareness of the ethical dimensions of the curriculum that previously had not been identified as part of the domain of ethics education.

The proposed Ethics MCSL was brought to the faculty group responsible for the undergraduate curriculum. Time allocation for the core content units of the MCSL was equivalent to a two-credit conventional course, with augmentation content bringing the total to four credits. The proposal, incorporating overall course objectives and objectives for each unit within existing courses, was approved by faculty. (See Figure 1 for objectives and Figure 2 for time allocation of classes at each level of the curriculum). To ensure accountability, it was determined that two faculty members would have the Ethics MCSL as part of their workload, with core classes to be taught by these individuals.

Having the support of faculty and formal approval of the Ethics MCSL within the School of Nursing, we sought and obtained a three-year grant from the Fund for the Improvement of Postsecondary Education (FIPSE) to further develop, implement, and evaluate the model, which was initiated with the class entering Fall, 1987. In addition to providing ethics education for baccalaureate students, the project is also designed to enhance the ability of faculty colleagues to use the rich examples inherent in students' clinical experiences to assist them in using concepts an principles that apply to ethical conduct in nursing. To respond to the identified national need to prepare morally sensitive and ethically literate graduates, the Ethics Education Project includes plans for dissemination of the model, teaching-learning strategies and materials, and project outcomes to nursing educators throughout the country by means of a national conference and the publication of a manual. External funding enabled us to assemble a project staff that includes both nursing educators and philosophers with a background in bioethics.

The Ethics MCSL is designed, as Bok (1988, p. 42) suggests, ". . . not to impart 'right answers' but to make students more perceptive in detecting ethical problems when they arise, better acquainted with the best moral thought that has accumulated through the ages, and more equipped to reason about the ethical issues they will face in their own personal and professional lives." Educational strategies are based on the four components of moral

FIGURE 2

OVERALL COURSE OBJECTIVES FOR ETHICS MCSL

1. Appreciate the nature and complexity of ethical issues in the practice of nursing.
2. Articulate an evolving personal ethical philosophy and relate it to an evolving philosophy of nursing.
3. Describe resources, relevant to ethics, such as committees, organizations, and media, indicating how these might be used in professional development and practice.
4. Make ethical decisions after critically analyzing the situation and applying ethical principles, theories, and codes.
5. Take actions which are congruent with the ethical decision.
6. Evaluate the relationship between the student's own personal ethical philosophy and his/her personal and professional behavior.
7. Progress in level of moral reasoning toward more principled reasoning.
8. Recognize the independent responsibility of the nurse with respect to ethical concerns in practice.

TABLE

STEPS IN THE PROCESS OF DEVELOPING A MCSL

1. Analyze curriculum for existing content and its placement.
2. Delineate content domain.
3. Develop a syllabus for a vertical course, including content placement, overall and unit objectives, teaching strategies, and evaluation methodologies.
4. Secure faculty approval.
5. Assign core teaching responsibility to content experts.
6. Provide for faculty development in content domain and its application.
7. Provide consultation to faculty involved in augmentation and clinical application.

behavior identified by Rest (1982): moral sensitivity, moral reasoning, moral commitment, and moral action. Forthcoming articles will explicate the work of the project staff in implementing and evaluating the Ethics MCSL. We will describe specific educational strategies used at varying levels of the curriculum to assist students to achieve the desired ethics-related learning goals.

Evaluation

Evaluating student learning is an essential part of a vertical course such as a MCSL just as it is for a traditional course. In addition, a second level of evaluation is necessary to determine the effectiveness of the MCSL as a curricular approach.

Student achievement of objectives specific to the Ethics MCSL unit in each course is being evaluated. Methods for assessment of learning include test questions, graded projects, journals, and sections of a care plan or larger course paper. Scores from test items and/or assignments contribute to the grade for that course. At the end of each year, evaluation data for individual students are compiled and an ethics grade for that level is computed and shared with each student.

The project also includes a quasi-experimental research design in an effort to determine the effect of the Ethics MCSL on the development of moral reasoning of students. A class of students who entered the program prior to the introduction of the Ethics MCSL is the control group and the first class taking the Ethics MCSL is the experimental group. Upon entry into the nursing program, both groups took the Defining Issues Test (Rest, 1979) and the Nursing Dilemma Test (Crisham, 1981). They will repeat these tests at the conclusion of the program and the posttest scores for the two groups will be compared. Appropriate statistical controls will be introduced in an effort to control for preexisting group differences, both in moral reasoning and in other possibly confounding variables such as age, sex, grade point average, and previous college education. Thus it may be possible to differentiate between the developmental change in moral reasoning which can be expected to occur during the college years and that which resulted from an ethics education intervention.

Data regarding the clinical performance of each student in the experimental group will be made available to project staff so that the relationships among moral reasoning scores, ethics grades, and clinical behavior can be explored. These findings of the nature of the relationship between moral reasoning of nurses and their clinical behavior would allow comparison with the study of pediatric residents done by Sheehan, Husted, Candee, Cook, & Bargen (1980), who found that moral reasoning is a predictor of clinical performance.

Applicability of the Model

A model such as the MCSL holds promise of value not limited to ethics content. Gerontology, sexuality, politics, or

culture are examples of content areas that might be incorporated into a curriculum via a MCSL. The use of a matrix that combines such vertical courses with traditional courses sequenced throughout a program forms a structure for knowledge delivery that can be kept current without necessitating major curriculum revisions. The model also has the potential to effectively use the interest and expertise of faculty who are specialists in various aspects of nursing. A test of the utility of such a model as a mechanism for integrating content within a nursing curriculum will be provided by the carefully planned implementation and evaluation of this Ethics MCSL that is made possible by support from FIPSE.

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Wrestling with the Larger Picture: Placing Ethical Behavior in Clinical Situations in Context

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ABSTRACT

This article provides an account of the use of a model-building process as an educational strategy for the teaching of ethics. Designed to integrate students' growing knowledge and skill in nursing with their intellectual and professional development, this model-building process has its theoretical foundations in cognitive moral development theory, and in an integrative approach to nursing education called Multi-Course Sequential Learning (MCSL).

Introduction

This article describes an active learning experience used in an ethics unit in the first nursing course at the University of Minnesota School of Nursing. The educational experience was developed as part of a three-year project for integrating ethics education in the curriculum of the undergraduate program in nursing. (Ryden, Duckett, Crisham, Caplan, and Schmitz, 1989). The project has enabled the development of teaching strategies and evaluation measures.

During the first ethics class, a student posed the question: "But don't we have rules to tell us what to do?" This question reinforced our view that students need to understand relationships among components that influence moral action in a clinical setting. They need to recognize that "rules," such as institutional policies, are useful, but are not in themselves sufficient guides to moral conduct. The purpose of the active learning experience we constructed for students was to help them understand that ethical behavior in a clinical situation is influenced by a number of factors.

Theoretical Framework

As a way of visualizing the theoretical underpinnings for this educational strategy, Figure 1 depicts interrelationships among nursing, ethics, and moral psychology. The intersection of these three domains represents ethical decision making and moral action in nursing situations. Because students are learning the professional practice of nursing, all ethical decisions by nurses occur within the domain of knowledge in the discipline of nursing. The domain of ethics provides moral knowledge derived from ethical theories about principles and virtues.

In the domain of moral psychology, the cognitive development theory articulated in 1932 by Piaget (1965) gave rise to the stage-theory of moral development enunciated by Kohlberg (1969). Kohlberg identified a hierarchy of six stages of moral reasoning: obedience to authority, self-interest, interpersonal concordance, law-and-order, social consensus about rights, and universal principles of justice and fairness. Ethical decisions are made by nurses who are at different stages of moral development, and who apply theory to practice through their individual understanding of ethical principles and virtues. The active learning experience we created for our nursing students required them to incorporate components of the domain of ethical decision making into a model.

Strategy

In the model-building task, we challenged students to place ethical behavior in clinical situations in context: to wrestle with the "larger picture" by considering the multi-

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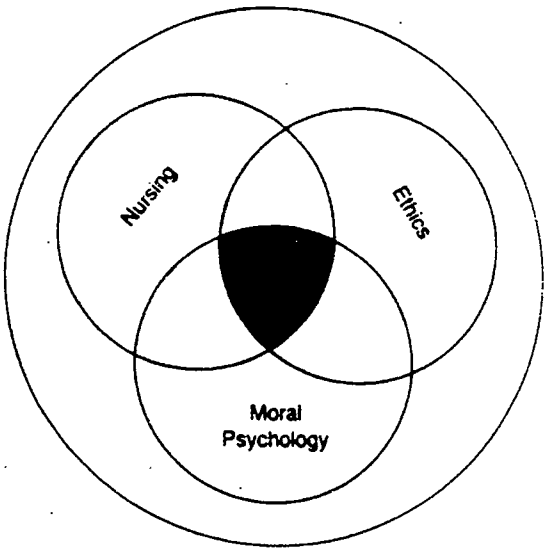
FIGURE 1

THEORETICAL MODEL FOR ETHICS EDUCATION IN NURSING



ple influences on moral action in a clinical situation. Working together in small groups, students constructed a conceptual model that depicted their view of the relationships among a given set of components. These components included: 1) universal ethical principles, 2) personal beliefs, attitudes, and values, 3) formal codes, 4) institutional and professional guidelines and procedures, 5) law (case and legislation), 6) a systematic process, 7) a clinical situation, and 8) ethical behavior. We recognized that before students could do the synthesizing required by this assignment, they would have to meet other lower level learning outcomes (e.g., learn the definitions of the components, comprehend the components, and recognize specific examples of each component).

To stimulate students to meet the lower level learning outcomes, they had available to them prior to the class a handout that defined each of the components and other resources included in their course materials (American Nurses' Association, 1985; University of Minnesota School of Nursing, 1987; University of Minnesota, 1974; University of Minnesota, 1984; and State of Minnesota Statutes).

The students were divided into randomly selected groups of six or seven. Each group was provided an envelope containing the names of the components (each printed on a separate, small piece of transparency), a case situation, colored markers, tape, and a blank transparency for use with an overhead projector. Students were instructed to decide as a group how to order the various components into a model depicting their interrelationships. Although the materials students had read included definitions and examples of the components, these resources did not describe the relationships among them and the way the components together constitute the domain of nursing ethics.

As an abstraction in the model, the component "clinical situation" would be applicable to any nursing encounter. However, in the belief that students needed a concrete example of a clinical situation as a stimulus for their thinking, we provided the short case shown in Figure 2. In an attempt to develop moral sensitivity, we chose an "everyday" situation where a nurse was the decision maker. The focus was on ethics with a little "e," not a dramatic, headline-grabbing dilemma (ethics with a big "E"). Since the students would have their first clinical experience the next quarter in a long-term care facility, we chose an ethical problem regarding a resident in that setting.

We gave students clear directions for proceeding: 1) read the case situation; 2) discuss how the components relate to each other, 3) use the transparency to show these relationships visually in a model that could be used to analyze the case; 4) consider likely objections that another group might raise to your model; 5) address those objections; and 6) designate someone in the group to record a description of the model, as well as the rationale offered for building the model in the way you ultimately decide to build it. We informed students that a presenter for each group would be selected at random; therefore everyone in the group was to take responsibility for each group member's learning and preparedness (Johnson, Johnson, & Holubec, 1986, pp. 59-85).

Faculty members circulated among the groups, urging students to question their assumptions, and encouraging them to avoid making premature decisions and to consider objections to their view. Faculty served as facilitators, not as providers of answers. For twenty minutes, students engaged in animated discussion as they constructed their models. Then each group was called upon in random order, and a member selected at random presented the transparency of the group's model and described their rationale for ordering the components as they did.

Analysis of Models

There was no duplication of models among the seven groups, although there were similarities which enabled us to cluster models into three representative groups according to relative degree of sophistication. One of the least sophisticated models was presented by Group C (see Figure 3). In their oral presentation, this group indicated that clinical situations were the consequence of a systematic process, although that process was not identified. The group was able to identify that relationships existed between law and institutional and professional guidelines/procedures, as well as between the latter and ethical behavior, which, in turn, they said, was directly influenced by personal beliefs and values.

A somewhat more sophisticated model was offered by

FIGURE 2

CASE SITUATION

Mrs. H. is a widowed 83-year-old woman admitted to the nursing home three weeks ago to regain strength following gall bladder surgery. On admission, the plan was for her to remain about six weeks and then to return to her home. Mrs. H. is making excellent progress medically and is quickly regaining her ability to perform activities of daily living. Her roommate, Mrs. P., is intermittently confused, usually at night. She gets out of bed and/or talks to herself. Mrs. H. has mentioned her roommate's behavior to her daughter. Mrs. H.'s daughter has insisted that her mother be moved to another room or she will transfer her to another nursing home. The nurse goes to Mrs. H.'s room to discuss this matter with her.

Nurse:	Your daughter called last Friday and asked if there was another room available for you. She is concerned that you are not getting the rest you need to recover because Mrs. P. is noisy during the night. After a lot of discussion, the staff has decided to move a number of people to different rooms so that you can have a different roommate. We will be making the changes this afternoon. Now, don't worry, we will do all the work. All you have to do is walk down a few hallways and you'll be in your new room.
Mrs. H.:	(surprised look on her face) No, no. I don't want to move. I'll only be here another couple of weeks. Besides, I like Mrs. P. We're just getting to know each other. No, it's not necessary to move.
Nurse:	It's no problem! Your daughter is concerned about your sleep. I think we should move you. Think about it a little and I'll come back in a bit to chat again.

Group B (see Figure 4). In their verbal presentation, Group B indicated that formal codes develop from laws and from institutional guidelines. They said that personal beliefs and values should develop from universal ethical principles. In their view, ethical behavior was the result of applying those beliefs in a systematic process. The clinical situation, they said, is where ethical development and imminent behavior come into focus for a specific outcome.

The most sophisticated model was that presented by Group E (see Figure 5). After some opening remarks, their presenter uncovered the left third of the model, the portion labeled "Input." This group identified the following as input: universal ethical principles, they said, gave rise to 1) an individual's beliefs and values; and 2) a tripartite set of what they called "corporate beliefs" including institutional and professional guidelines and procedures, formal codes, and case and legislative law.

Next, the presenter uncovered the center third of the model which is labeled "process," and identified a systematic process that a nurse goes through. Personal beliefs and corporate beliefs interact with and modify each other. In their modified forms, individual beliefs and values and corporate beliefs function as filters through which clinical situations are understood and systematically processed by a nurse, leading to output. At this point, the presenter uncovered the right third of the model, labeled "output." Ethical behavior as a student and as a nurse was viewed as behavioral output.

Discussion

The least sophisticated group, Group C (see Figure 3), did not clearly recognize the relationship between universal ethical principles and law or that between codes and guidelines. They saw those universal principles as an equal partner to ethical behavior as informed by their personal beliefs and values. The perspective they took was their own personal perspective as nurses. This model may be a realistic representation both of the approaches to ethical decision making actually taken by practicing nurses and of the approach that some student nurses actually will take. In this model, ethical behavior as a student and as a nurse was going to be affected as much by a nurse's personal beliefs and values as by any other component of the process.

The somewhat more sophisticated model offered by Group B incorporated written-in explanations and qualifications. The model evidences awareness of the concept of revisability: that codes and institutional guidelines should always be revisable in light of our understanding of those original basic ideas. In Kohlberg's scheme, this is an ability that characterizes Stage 5 moral reasoning. This model indicated some awareness that professionals have a duty to act on an informed conscience: they must go through this systematic process and adopt tentative behavioral decisions which are then further processed in light of an understanding of legal requirements in particular clinical situations. In Kohlberg's scheme, this is a Stage 5 social consensus perspective insofar as it calls for an interpretation of the clinical situation in light of the law, and in light of all of the other components. The perspective is idealistic, yet realistic in that it evidences a commitment to the process.

The presentation of the most sophisticated group, Group E, demonstrated a clear understanding of the theoretical relationship of principles to laws, codes, and individual belief systems. In attempting to achieve a balance among universal ethical principles, corporate beliefs, and personal beliefs and values, Group E's model comes closest to reflecting an awareness of the highest level of moral

FIGURE 3
GROUP C'S MODEL

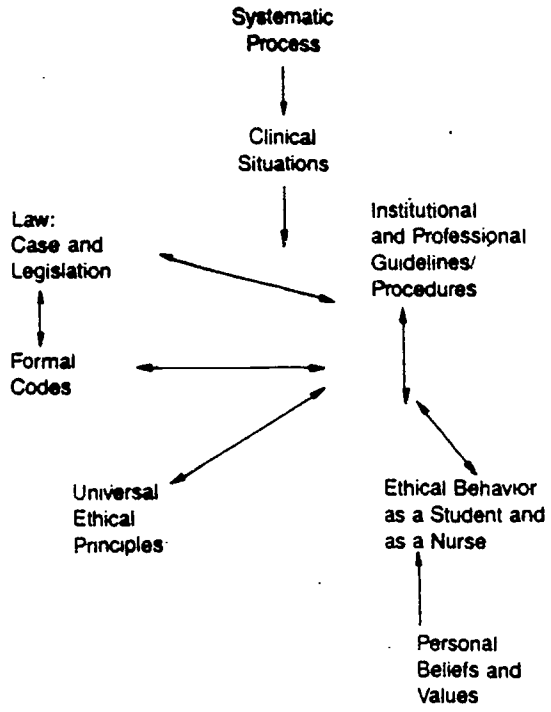
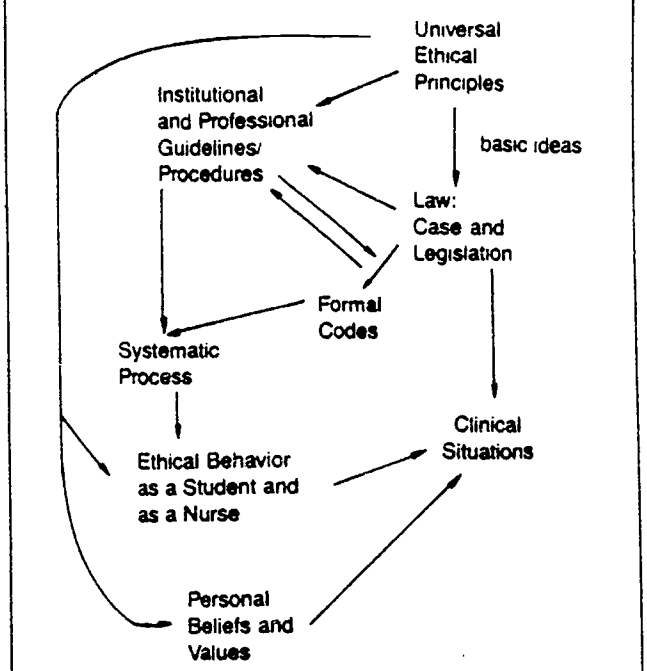


FIGURE 4
GROUP B'S MODEL



reasoning, Kohlberg's Stage 6. This model was the most coherent and the most logically organized. This group's approach to the entire activity appeared to be the most methodical. Their presentation was also the most coherent and the most concise.

The entire class was impressed by this group's ability to organize their model based on the Roy (1984) model which had been used in the course. Group E's presentation drew enthusiastic applause. Other students intuitively recognized a clear and appropriate model. It is possible that other students recognized the leadership potential of those who organized abstract concepts in a methodological, meaningful way, and who presented those concepts by building on previously learned material with which the audience was familiar.

Conclusion

According to contemporary moral theory, the ability to value the perspective of another is a mark of moral objectivity. Similarly, the ability to anticipate objections others might raise to one's position, as well as the disposition to entertain challenges to one's viewpoint marks a rejection of ethical egotism. The ability to reconsider and perhaps revise one's position is an important indicator of principled reasoning which characterizes the highest levels (Stages 5 and 6) of moral development.

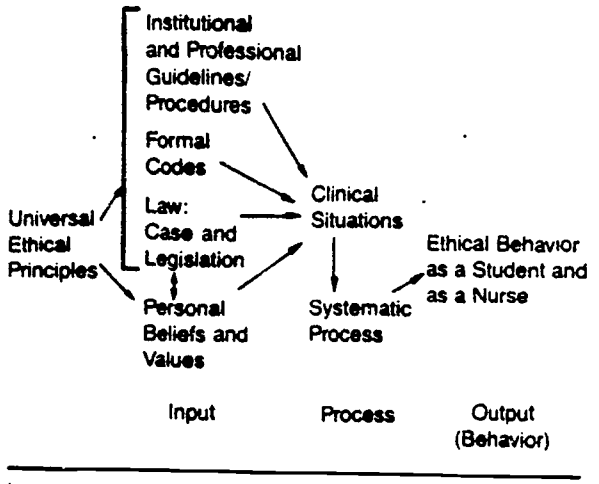
One result that we expected, but which did not materialize, was that the groups would anticipate objections to the way in which their model was constructed, and to their rationale for constructing their model as they ultimately did. No one challenged any of the models presented. This perhaps indicated that we as faculty either expected too much from this group of sophomore nursing students or needed to help students to challenge each others' models and to discuss each others' objections.

Faculty and students learned that some models are clearly more sophisticated than others. This variability may reflect differences in ability to think abstractly, as well as dissimilarity in individual students' commitment to doing background readings, and to contributing to a group effort. One important thing faculty learned is that students welcome opportunities to work collectively, to take responsibility for group endeavors, and to assume new challenges. We also verified that students can learn by experience that professional ethics is not simply a matter of acting on the personal values learned in childhood.

Students discovered through an active learning method that professional ethics requires more than obeying laws, codes, guidelines, and regulations. They learned that it is

FIGURE 5

GROUP E'S MODEL



not only the outcome of their decision making process that is important but also the appropriateness of the component parts of that process, the rigor and care with which that process is completed, and the need to involve peers in that process.

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Developing Case Situations for Ethics Education in Nursing

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ABSTRACT

Developing cases for the clinical teaching of ethics can be extremely time-consuming. Often, the cases that are developed either represent unrealistic situations or mere technical puzzles rather than genuine ethical problems. This article describes how faculty at the University of Minnesota modified a simple, quick and inexpensive think tank technique, the Crawford Slip Method, for use with nursing educators to generate an extensive list of ethical issues within each clinical specialty. Selecting from these lists, faculty in each specialty developed one realistic nursing case situation to illustrate selected ethical issues. Faculty were asked to use the Alverno College criteria for designing a moral dilemma when writing their cases. Suggestions for adapting the cases for multiple uses are presented.

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Acknowledgment

The cases presented in this article were generated by University of Minnesota School of Nursing Faculty and Graduate Students at a workshop in Spring 1988. Their efforts in creating provocative cases for use with students are gratefully acknowledged.

Introduction

This article describes the use of a case-building activity with a group of clinical faculty for the purpose of developing realistic ethical problem situations arising out of a number of nursing specialty areas suitable for teaching ethics to baccalaureate nursing students. This strategy was used as part of a larger ethics education project supported by a grant from the Fund for the Improvement of Postsecondary Education (FIPSE) (Ryden, Duckett, Crisham, Caplan, & Schmitz, 1989).

Rationale

The case building activity took place in a faculty workshop entitled, "When Teaching Ethics is Everyone's Responsibility" (Duckett, Schmitz, Waithe, Crisham, Caplan, & Ryden, 1988). In addition to generating real world cases to serve as a stimulus for students' moral reasoning activities, we expected that the case building activity would also increase the sensitivity of faculty to the ethical dimensions of situations they commonly encounter in their clinical teaching. This activity thus served as one means of accomplishing an important goal of the project: to enhance the ability of faculty to draw upon the rich examples inherent in students' clinical experience so as to assist students in using concepts and principles that apply to ethical conduct in nursing.

The construction of cases for the clinical teaching of nursing ethics can be extremely time-consuming, and the products created can be inappropriate for their purpose. Cases developed by practitioners who are ethics educators tend to reflect the experience of their developers. That experience is frequently limited to firsthand knowledge of a few specialty areas within a profession. Cases developed by

practitioners who are not ethics educators sometimes spell out too clearly the ethical issues and their resolution. Such cases have limited educational value in that they do not require students to develop skills of ethical sensitivity and reasoning.

Alternatively, the problem posed by some cases is not primarily ethical, but rather a technical puzzle that can be solved through increased expertise in the subject matter. Cases developed by philosophers can pose thorny ethical dilemmas, but tend to be so hypothetical that the lack of technical realism makes it difficult for students to see the relevance of ethics to their professional education. What is essential for successful development of ethics cases suitable for clinical teaching in nursing is the collaboration of a number of practitioners in the clinical field with philosopher ethicists and with nurse ethicists. But extensive collaboration can require a considerable amount of time from all parties.

In order to gather a large amount of information about ethical issues in a number of nursing specialty areas in a short amount of time, and to incorporate those issues into realistic cases suitable for the clinical teaching of nursing ethics, project staff adapted the ingeniously simple Crawford Slip Method (Crawford & Demidovich, 1983), for use in the nursing educators' faculty development workshop.

The Crawford Slip Method

The basic Crawford Slip Method provides think tank organizers with five minutes to define a target, and permits participants 10 minutes to write 10 ideas, each in terms of a simple sentence on a separate slip of paper. It involves inexpensive supplies (small slips of paper and two larger sized cards). The small slips are used by participants to capture a simple thought about a particular target problem or issue. The larger cards are used by organizers to classify ideas, and to group similar classes of ideas under "subproblems."

Slips are written anonymously in order to increase the likelihood that the most difficult problems will be recorded without fear of recrimination or exposure. Anonymous slips give all participants equal influence in identifying and defining issues independent of pressures to protect superiors, colleagues, or employing institutions. Controversial issues are easier to raise, and all persons' views are given an equal chance. The production of a number of slips on an issue can reveal the existence of consensus on issues for which consensus might otherwise be difficult to acknowledge (Crawford & Demidovich, 1981). We modified this basic method to permit its use in the construction of nursing ethics cases by nursing educators.

Procedure

Participants in the ethics education workshop for faculty were grouped according to nursing specialty areas and asked to identify as many ethical issues of concern in their specialty area as possible. They were urged to list those issues that were most frequently recurring, most serious in terms of consequences to specific individuals, and/or the most widespread in terms of numbers of people affected. We used 3M Post-it Notes®, and large newsprint instead of the slips and classification cards recommended by the Crawford Method. A batch of 10 notes was distributed to each person with directions to jot down a simple phrase or declarative sentence on each slip expressing one ethical issue, problem, or concern.

After 10 minutes, participants were asked to affix their slips to the large newsprint page for their specialty area and confer with others in their specialty group as to how each reported issue should be categorized in terms of general moral issues. They were instructed to construct an organizational chart of ethical issues for their specialty by creating column headings identifying each of the general categories of moral issues, and affixing the 3M Post-it Notes® containing examples within that column. A volunteer from each specialty area presented the categories and examples of issues from each category to the entire audience. This gave specialists in other areas a clear idea of similarities and differences in ethical issues arising in other specialties, as well as a general overview of the great range of issues within nursing itself.

The next step was for each group of participants to construct at least one ethics case for their specialty, drawing on the previously identified classification of issues. Using their newsprint organizational chart, groups worked for 20 minutes to construct and write up a case. They were instructed that the case should be realistic (preferably drawn from experience), should not spell out the ethical issues or resolve them, should not require highly expert knowledge beyond that expected of a nursing student, and should be an ethical dilemma rather than clinical or technological puzzle. These instructions are based on criteria developed by Alverno College for designing a moral dilemma (Alverno College, 1979).

Ethical Issues Identified

Within the specialty groups there was both a wide range of issues and significant replication of issues listed. This reflected the range of moral issues within the specialty, as well as the prevalence of particular kinds of issues. Table 1 lists specialty areas, categories of moral issues, and number of examples of each issue.

Cases Generated

The cases constructed by some groups included brief situational descriptions followed by a list of questions. Other groups described situations without posing any ethical questions facing the nurse. The cases, as written,

TABLE 1

TYPES OF ETHICAL ISSUES IDENTIFIED BY CRAWFORD SLIP METHOD

Specialty Area:	No of Slips	Problems in Exemplifying Nursing Values Of:			Issues Related To:						Conflict of Interest or Values Between:						
		Compassion	Genuineness	Honesty	Autonomy of Client	Autonomy of Client's Family	Nurses' Autonomy	Informed Consent	Paternalism	Respectful Treatment	Client-Nurse	Client-Family	Client-Institution	Client-Society	Nurse-Institution	Nurse-Society	Clients
Child & Maternal Health	48	17	10	7	21	15	7	9	14	16	8	8	8	13	2	8	0
Critical Care	30	10	2	9	12	11	1	8	7	10	12	7	7	10	3	1	9
Gerontology	41	9	4	0	27	19	0	7	14	11	4	17	9	15	2	3	3
Community Health	31	5	1	2	2	3	1	2	2	2	4	0	2	10	6	5	0
Medical	20	2	0	1	3	0	2	2	0	0	2	1	1	0	2	2	2
Mental Health	36	10	3	1	14	8	2	8	10	12	3	4	10	13	0	0	0
Nursing Education & Professional Issues	24	1	1	1	0	0	2	0	0	1	3	0	2	2	6	5	0
Research	33	1	5	10	7	1	6	7	2	3	9	1	4	11	11	14	0
Totals	263	55	26	31	86	57	21	43	49	55	45	38	43	74	32	38	14

have the potential for being useful for a number of educational purposes. Framing further questions to stimulate thought and discussion would depend on the specific objectives of the teacher and the underlying theoretical framework. This is addressed in the subsequent section on Utilization of Case Situations.

Cases that were developed by faculty at the workshop are presented below. Material in brackets has been added by the authors to achieve a consistent narrative format.

Child Health

Eight-year-old Hilary is scheduled for a bilateral nephrectomy this morning. Her parents demanded that the nursing staff not tell Hilary that this surgery was planned because previously Hilary has become extremely distressed when informed of procedures. As a result, she has not had pre-op teaching. [You will have primary nursing responsibility for Hilary's post-op recovery. What should you do, and why?]

Child and Maternal Health

A 15-year-old primipara is diagnosed as having gestational diabetes. She is non-compliant with dietary modifications, prenatal visits, and tests of fetal well-being. The physician believes that hospitalization is mandatory to preserve fetal health status. The mother refuses to be admitted. [The physician indicates that she would like to have you assist in gaining the cooperation of the teenager's parent and possibly a court order if that is needed to achieve hospitalization. What should you do, and why?]

Gerontology

Sean O'Reilly is an elderly diabetic, recently widowed, hospitalized for treatment of an infected foot ulcer. Sean lives in rural Minnesota and wants to return to his farm home that has bathroom facilities only on the upper level. He has also been somewhat forgetful with regards to his meals, insulin, and foot care.

A son and daughter-in-law live in a nearby community; however, both are employed full-time. Sean frequently calls his son for assistance at all hours of the day. The family reports this as increasingly disruptive of their privacy, energy, and family life. The son and daughter-in-law have expressed a preference for Sean's placement/admission to a nursing home, [and ask you to help achieve Mr. O'Reilly's transfer to a facility near them upon his discharge. What should you do, and why?]

Community Health

A one-year-old child suffering from chronic ear infections has received health-care treatment at different HMOs on a fee basis. However, care has been fragmented due to the cyclical unemployment of the child's father who is in the entertainment business. Due to unemployment, the family has access only occasionally to transportation. Although the family qualifies for care at the County Medical Center, they do not live near public transportation. They cannot afford fee-for-service care at the nearby HMO clinic. The father is white and of a middle-class background; the mother is from Latin America. [Both believe in the importance of the father as breadwinner and the mother remaining at home to care for the children, ages 1, 3 and 6. The oldest child is in kindergarten half-days.]

The parents are loving, concerned and responsible traditional parents and are highly motivated to function as well as possible within present economic contraints. [As a nurse, you are concerned that the youngest child's chronic infections be monitored and treated; however you do not want to intrude into the family's dynamics or impose your own values on this vulnerable, but functional family unit. What should you do? What are your reasons for this decision?]

Medical

[You are a 32-year-old nurse, with eight years nursing experience.] You work on a medical unit of a teaching hospital. [You are four months pregnant and the mother of a three-year-old.] Chris is a 30-year-old patient with AIDS admitted to the medical-surgical unit. You will be responsible for his nursing care, including dressing changes and routine care. Chris' insurance carrier mandates a double room and, until now, the other bed in Chris' room has not been needed.

However, this afternoon a patient [who is scheduled for surgical removal of kidney stones] has been assigned to [the only available bed on the unit which is in] Chris' room. You are concerned about protecting other patients, visitors, and yourself [from unsafe contact with possibly infectious materials, particularly because the chart indicates that overnight Chris experienced several bouts of vomiting and diarrhea. What should you do, and why?]

Mental Health

A 65-year-old male with a history of severe depression has been insomnious and unwilling to eat for several days. He complains of malaise and that no one is helping him. The patient has been taking [Elavil for several months] without effect, and, according to the chart, responded well to ECT (electro-convulsive therapy) in the past. He says that he doesn't remember ever having had ECT and refuses to consent to ECT treatment now. [You are concerned about possible malnutrition and dehydration although there is no clear indication of either at present. What steps should you take, and why?]

Critical Care

A 26-week pregnant mother of two has been admitted with an intracerebral hemorrhage and remains comatose with an uncertain prognosis. [The husband has been actively involved in his wife's care and has consulted with you and other nurses on a daily basis.] Now, fetal monitoring indicates early signs of distress. The trauma of a C-section will decrease the patient's chance of survival, and the chance of fetal survival with or without preterm delivery is uncertain. [Meeting with the husband for the first time,] physicians recommend a C-section.

Continuation of present treatment is of questionable benefit to the mother [they explain, and delivery might be the baby's only chance. The husband says he doesn't think he wants his wife to undergo the C-section. The physicians advise him that he probably has only a few minutes to think about his decision. Ten minutes later, he asks you, "What do you think would be best?" How should you respond?" What are your reasons?]

Nursing Education

The State Nurses' Association House of Delegates is impatient to increase the educational requirements for entry into the profession. This has been a goal for more than 20 years. Work towards its implementation has been sporadic. There is currently an acute shortage of nurses throughout the state. The shortage is more severe in some metropolitan areas and is expected to worsen over the next decade. There is also compelling evidence that nurses need to be prepared for practice in a way that enables them to deal with ever-increasing complexities inherent in health care, (e.g., constant innovations in technology and organization of services, and clients who are acutely ill and hospitalized for short terms then discharged to their homes with continuing need for nursing care).

Members of the association are divided on whether or not to press ahead at this time for increased educational requirements. Some feel that increasing educational requirements will ultimately, inevitably, reduce the supply of nurses, and reduce access to the profession for minority and disadvantaged students. Others argue that increased educational requirements are needed if graduates are to be able to deliver quality comprehensive care.

They also argue that such a policy will enhance the image of the profession to attract more talented students who might otherwise enter another profession. [You are well-respected by members of the association who seek your

TABLE 2

QUESTIONS TO STIMULATE CASE ANALYSIS DERIVED FROM REST'S FOUR-COMPONENT MODEL OF MORAL BEHAVIOR (REST, 1982; 1986)

Component 1 Moral Sensitivity (Realizing there is a moral problem)
1. Who are the parties in this situation?
2. Who is affected by this and how?
3. Whose rights/values are in conflict and what are those rights/values?
4. What are the possible actions and the potential consequences of each?

(Bebeau, Rest & Yamoor, 1985)

Component 2 Moral Reasoning (Deciding what is the right thing to do)
1. How do you weigh conflicts among rights, principles or values?
2. Is it more important to preserve or protect some rights/principles/values over others? Why?
3. Considering all of the above, morally speaking, what ought the nurse to do?

(e.g., Beauchamp & Childress, 1983; Frankena, 1973)

Component 3 Commitment (Giving priority to moral values over other competing values)
1. Suppose you were really in this situation. Do you believe you would do what you said the nurse ought to do?
2. Would you still be able to do this, given any possible negative consequences to yourself (including the loss of potential benefits from some other course of action)?
3. What specific personal negative consequences might prevent or limit your acting as you say the nurse should?

(Rest, 1983)

Component 4 Implementation (Taking moral action)
1. Given that there may be many ways to carry out a moral decision, what methods might limit potential negative consequences?
2. How might you speak to the parties involved? What might you say?
3. What interpersonal skills are most likely to enhance your ability to carry out the actions you have decided upon?
4. What kinds of objections might be raised to your decisions? Explain your decision in a way that addresses those objections?
5. What will you *actually* say and do?

(Egan, 1986; Hall, 1986; Fisher & Ury, 1981)

opinion. What should you say, and why?]

Research

Mr. Johnson, a student nurse, is caring for Mrs. Knight who had surgery 36 hours ago. Mrs. Knight has consented to participate in a research study for which data is being collected while she is in the hospital. This is a double-blind study comparing the effectiveness of three medications: A, B, and C. Mr. Johnson has noticed that patients who are on drug C do not appear to receive adequate pain relief. His clinical instructor is one of the researchers conducting this study.

In clinical conference this morning the instructor stressed the importance of following the risk protocol exactly and collecting the necessary data. The instructor emphasized that they are in the final stages of data collection and have already lost a significant number of subjects due to not following protocol. Mrs. Knight has been receiving drug C every 4 hours since surgery and now refuses to ambulate, cough, or breathe deeply. She is becoming increasingly agitated and says to Mr. Johnson: "I'm so miserable. Isn't there anything you can do?" [How should he respond to the patient's question, and why?]

Utilization of Cases

We find the quality of the cases quite high in that each case meets the criteria recommended under the Alverno system. The cases are open-ended and likely to elicit different viewpoints. Facts are specified, but the ethical issues are left to the observer to articulate. The problems are timely and reflect situations that nurses are likely to experience, and over which a professional is likely to experience conflict. Professionals are likely to disagree about solutions to the problems in part because alternative solutions reflect individual preference for assigning different weights to conflicting moral values. Each case raises a number of moral concerns while including non-moral issues about technical details and interpersonal communication techniques. Importantly, each case asks the reader to assume the role of the nurse in the situation.

We plan to use selected cases with students differentially to help them develop the requisite skills for ethical behavior. We are basing our determination of those skills on the work of Rest (1982; 1986), who has proposed a four-component model of the processes that must occur in order

for a person to take moral action. These processes do not occur in a linear fashion, but are recursive.

The first component is moral sensitivity. To become morally sensitive in a particular situation, the person must engage in cognitive-psychological processes that cause her/him to recognize that because the rights, interests, needs and/or values of the parties to the situation are in conflict, a moral problem exists. The second component, moral reasoning, occurs when the person weighs conflicts among rights, principles, and/or values, determines which should take priority, and decides which course of action is the most morally defensible.

Commitment, the third component, involves giving priority to moral values over other competing values so that one decides to actually do that which one believes is morally right. The fourth component, implementing the moral action, requires that the person has certain psychological attributes (e.g., ego strength, self-regulation skills) and certain interpersonal skills (e.g. communication, assertiveness, conflict resolution) to help overcome barriers to ethical action,

This model helps explain the multiple dimensions of moral behavior. It also provides guidelines for how educators may use situations such as the cases included above to accomplish multiple educational objectives. As the situations are written, they elicit moral reasoning more than any other component of Rest's model. By using the same situation, with different sets of questions, the educator can help students develop skills required by each component of Rest's four-component model. Table 2 lists each component of the model and examples of questions that correspond to that component.

Conclusion

Although the basic Crawford Slip Method has been used extensively with professional groups, this represents its first use, we believe, with nursing educators. The modified Crawford Slip Method required a minimum amount of time and expense to generate and organize lists of ethical issues that arise with frequency in nursing. The strategy helped to stimulate faculty awareness of the range and specific nature of ethical concerns within specialty areas of nursing.

Participants were then able to quickly generate a good first draft of one case per specialty area that dealt with one or more of the identified issues. With Table 2 as an instructional guide, the cases can be used for the clinical teaching of nursing ethics. The strategy also gave nursing educators the opportunity to demonstrate to themselves that without specific training in ethics education, they can create stimulus materials for the clinical teaching of ethics by collaborating with others in their nursing specialty area.

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Using Structured Controversy to Promote Ethical Decision Making

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ABSTRACT

This article describes the use of structured controversy as an educational strategy for helping students learn content and skills needed for dealing with difficult ethical situations that arise during the practice of nursing. Structured controversy, an innovative technique that encourages learners to deal with conflict constructively, is described, and research validating its benefits is reviewed. A comprehensive description of how structured controversy was operationalized, using the issue of whether or not to give nutrition and hydration to a dying patient, is included to provide other nursing educators with an illustration of how this strategy can be applied.

Introduction

During a class on ethical decision making, a nursing instructor describes this situation: Twenty-two-year-old Sara Olsen was diagnosed 2 years ago as having a malignant, inoperable brain tumor. She is being cared for at home by her parents, a home care registered nurse, and nursing assistants. This week, her disease has progressed to the point that she is unconscious most of the time and incapable of eating or drinking. Periodically, she reacts to painful stimuli, voices, or light. She no longer recognizes family members.

The instructor poses the difficult question of whether or not Sara's life should be prolonged by providing nutrition and hydration by artificial means (e.g., nasogastric, gastrostomy, or intravenous tubes). Some students say it would be wrong to let Sara starve to death, while others argue that it would be wrong to impose emotional, physical, and financial burdens on Sara's family by artificially prolonging her life. A conflict such as this is inevitable as students grapple with ethical issues.

Suppose that you wanted your nursing students to wrestle with the ethical dilemma described earlier and reach a morally defensible conclusion concerning the plan of care that they would recommend for Sara Olsen and her family. What approach could be used with a large class that would help students to become informed about this ethical problem; to articulate diverse perspectives regarding the situation; to deal with conflict constructively; and to think critically about ethical principles, theories, and literature pertinent to this ethical problem?

This article describes an interactive learning strategy called structured controversy that represents one possible approach to accomplish educational goals related to issues about which people take significantly different positions. In structured controversy, conflict is presented in a manner that allows students within small groups to argue both for and against a specific position regarding a

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disputed issue, then reach a consensus. The following sections briefly delineate a conceptual basis for conflict and structured controversy, describe procedures for use of this strategy, and finally provide an example of its application to teaching about an ethical dilemma in nursing.

The Importance of Conflict

Conflict exists whenever incompatible activities occur (Deutsch, 1973). Conflict is determined by what is valued by the conflicting parties and by what beliefs and perceptions those parties hold. One of the creative functions of conflict lies in its ability to arouse motivation to solve a problem that might otherwise go unattended. Major features of productive conflict resolution are, at the social level, similar to the processes involved in creative thinking. These include the development of the conditions that permit the reformulation of the problem once an impasse has been reached; the concurrent availability of diverse ideas that can be flexibly combined into novel and varied patterns; and sufficient detachment from an original viewpoint to be able to see the conflict from new perspectives. Each of these major features is subject to influence from social conditions and the personalities of the problem solvers. The effectiveness of conflict resolution is influenced by the mixture of cooperative and competitive elements within the activity: the greater the cooperative elements and the less the competitive elements, the more constructive the conflict resolution (Deutsch, 1973; 1975).

Conflicts may arise in any good classroom discussion, but if conflicts are left ambiguous and unresolved, they may cause continuing trouble. Instructors need to help focus conflicts so that conflicts contribute to learning (McKeachie, 1986). Conflicts may aid learning by encouraging students to consider previously unexamined ideas with which others disagree. Conflicts stimulate interest and spark curiosity, thus increasing students' motivation to learn (Johnson, Johnson, & Johnson, 1976). Structured controversy has been developed as a learning strategy to maximize the potential benefits of conflict.

Structured Controversy: Procedures and Process

In structured controversy, students are divided into groups of four with two pairs of students in each group. Students are given informational resources representing both sides of the chosen controversial issue and instructions on how to follow the five basic phases of controversy. These phases are: plan positions and arguments with your partner; present your position as a pair; argue the issue forcefully and persuasively with the students holding the opposing position; reverse positions, and with your partner plan and argue the opposing position forcefully and persuasively; and drop advocacy of an assigned position, and both sides reach a consensus on a position that is supported by evidence and rationale. This position and its rationale may then be written and shared verbally with students in other groups or submitted to faculty for evaluation (Johnson, Johnson, & Smith, 1986).

Implementation of structured controversy can vary by using it during only one class period, or by using portions of this process successively over several class periods. Another variation is that students may either be given a bibliography of assigned informational resources or, when time is limited, students may be given brief summaries of facts or positions related to an issue with suggested points to argue when defending a particular position.

How does structured controversy work? The process by which structured controversy is effective is hypothesized to occur in this way: it begins when students categorize and organize their present information and experiences related to the issue being considered, and derive a conclusion from them. Then, when students realize that others have a different conclusion that challenges the students' original conclusion, a state of internal conceptual conflict, uncertainty, or disequilibrium is aroused. This uncertainty motivates a search for more information and a more adequate cognitive perspective and reasoning process to resolve the uncertainty. The more adequate cognitive perspective and reasoning process is derived from more accurately understanding the cognitive perspective and reasoning process of the students' opponents, and adapting the students' own cognitive perspectives and reasoning process accordingly. A joint agreement is reached following open discussion of the issues, and in reaching this joint conclusion, students employ their new cognitive perspective and reasoning process. This results in a higher quality and more creative conclusion than the students' original conclusion (Johnson & Johnson, 1979).

Research About Structured Controversy

Structured controversy has been used with students at grade school, high school, and college levels. Research studies done with students at these various educational levels have compared the effectiveness of structured controversy with other learning strategies of concurrence-seeking, individualistic learning, and debate. Controversy is defined by Johnson and Johnson (1979, p 53) as "a type of conflict that exists when one person's ideas, information, conclusions, theories, and opinions are incompatible with those of another person and the two seek to reach an agreement." Concurrence-seeking occurs when members of a group inhibit discussion to avoid any disagreement or arguments, emphasize agreement, and avoid realistic appraisal of alternative ideas and courses of action. Individualistic learning occurs when students work alone without interacting with each other, in a situation in which their goal attainments are unrelated and independent. Debate involves two parties arguing incompatible

positions on an issue, with a judge determining which side presented the best position (Johnson, Johnson, & Smith, 1986).

Research results indicate that when compared with concurrence-seeking, individualistic learning, and debate, controversy results in: greater student mastery and retention of the subject and greater ability to generalize the principles learned; higher quality decision making and solutions to problems; promotion of creative insights by encouraging students to view a problem from different perspectives and then reformulate the problem to include new insights; an increase in the number and quality of students' ideas, feelings of stimulation and enjoyment, and originality of expression in problem solving, resulting in greater emotional commitment to solving the problem, greater enjoyment of the process, and more imaginative solutions; and greater liking among participants, greater perceived peer academic support, higher academic self-esteem, and more positive attitudes toward the subject (Johnson & Johnson, 1988). With the use of controversy, repeatedly confronting students with the fact that different people have different points of view promotes cognitive development and growth in moral reasoning (Johnson, Johnson, & Johnson, 1976).

Research studies indicate additional benefits of structured controversy. One study concerning students who were and those who were not academically handicapped found that the goal and resource interdependence in the controversy condition led to increased concern about the learning of academically handicapped members (Johnson & Johnson, 1985). In a study with engineering students, controversy led to students' feelings of having more influence on the group decision and more satisfaction with the group report compared with students in the concurrence-seeking condition. Controversy also enhanced the working relationships among group members (Smith, Petersen, Johnson, & Johnson, 1986).

Another study compared negotiating styles in groups of high- and low-power students who operated in both a cooperative context (controversy) and a competitive context (debate). High-power students were those who had control over more resources valued by others. Results showed that, within the cooperative context, both high- and low-power students were highly inducible (a state of willingness to be influenced) to each others' influences, that needed resources were provided to each other, high trust and liking occurred between students, and students were more accurate in understanding each other's perspectives than were students in the competitive context. In contrast, within a competitive context, unequal power relationships were found to promote use of coercion as an influence strategy by high-power students; refusal to facilitate the achievement of each other's goals (both high- and low-power students withheld the resources needed by the other); belief that people will act in egocentric ways without concern for the other; belief that one can control the other; distrust of the other; inaccurate understanding of the other's perception of needs and goals; and dislike for the other (Tjosvold, Johnson, & Johnson, 1984).

Although controversy can produce the desired effects described earlier, this may not happen under all conditions. Positive results from controversy are more likely to occur when the following conditions are present. 1.) The controversy occurs within a cooperative goal structure, in which controversies are defined as interesting problems to be solved rather than as win-lose situations, and students are encouraged to work together. 2.) Controversy groups are heterogeneous (e.g., according to attitudes, cognitive perspectives, sex, background, information, ability levels, and skills), which enriches the resources and perspectives available to begin the controversy. 3.) An adequate amount of relevant information is provided that represents both sides of the issue. 4.) Students possess skills in collaboration and conflict management (e.g., disagreeing with others' ideas while affirming their personal competence), perspective taking (e.g., paraphrasing to demonstrate understanding and communicating the desire to understand accurately), differentiating (bringing out differences in positions) and integrating (combining several positions into one new, creative position). (Most controversies go through a series of differentiations and integrations. These skills may be learned while students participate in structured controversy). 5.) Students possess the ability to engage in rational argument by gathering, organizing, and presenting information, challenging, and disagreeing (Johnson, Johnson, & Smith, 1986). 6.) Students follow eight discussion rules proposed by Johnson & Johnson (1985, p 243) that promote cooperation among students, such as "I listen to everyone's ideas even if I do not agree."

Limitations of structured controversy also should be recognized. Balanced resources supporting the contrasting positions regarding a controversial issue may not be available. Using this learning strategy requires considerable faculty and student preparation time, yet time may be limited for both. Also, some students may lack the motivation and psychological energy for participating in interactive learning strategies (Johnson & Johnson, 1988).

Operationalizing Structured Controversy

How was structured controversy actually used to promote students' ability to reason about the dilemma facing Sara Olsen's family and caregivers? The following account regarding implementation of structured controversy with a specific class of nursing students may assist readers in using structured controversy for this or similar issues.

Students

The class for which this controversy was planned was comprised of 51 senior nursing students who ranged in age from 20 to 42. Forty were basic students and 11 were registered nurse students. They were taking a course that focused on concepts of stress and crisis. The course was taken during the second year of a curriculum in which

QUESTION: Should nutrition and/or hydration be withheld in the following situation?
Assume the patient is a 19-year-old woman who was diagnosed 2 years ago as having a malignant, inoperable brain tumor. She is being cared for at home by her parents and nursing assistants around the clock. This week, her disease has progressed to the point that she is unconscious most of the time and incapable of drinking or eating. Periodically, she reacts to painful stimuli, voices, and light. She no longer recognizes family members.

OBJECTIVE: Given the case above involving a patient for whom there is no hope of recovery:
a. present arguments for and against withholding nutrition and/or hydration;
b. critique the validity of the arguments presented by others;
c. defend your own position, against the critique of others, using rationale based on ethical principles and theories, law, nursing and medical knowledge, and other relevant considerations; and
d. prepare a written summary of conclusions reached by the group (conclusions may be those of the group as a whole and/or those of individuals), including rationale.

TASK: Work cooperatively in groups of four to accomplish the objective above. Refer to discussion format and timetable attached.

You may want to consider the following factors, but do not feel limited by them.

- Ethical issues
- Ethical principles
- Practical considerations
- Legal considerations
- Formal codes
- Professional guidelines
- Personal beliefs and values
- Institutional policies and procedures
- Rest's Four Component Model for Ethical Behavior
- Paradigm cases

Figure 1: Plan for structured controversy.

ethics was being integrated as described in a previous publication (Ryden, Duckett, Crisham, Caplan, & Schmitz, 1989).

Students' Background Knowledge of Ethics

This ethics curriculum is implemented via an approach called Multi-Course Sequential Learning (MCSL), whereby ethics content units are integrated into many of the courses in the nursing program. Students previously had studied ethical principles and theories, and had considered how these applied to selected clinical situations. They also had studied the issues of paternalism, competency, and surrogate decision making. All previously studied ethics concepts and course materials were considered foundational to this ethics class.

Rationale for Strategy and Topic Selection

According to many research studies, structured controversy promotes students' learning of content regarding controversial issues. The skills promoted by structured controversy will be needed after graduation as nurses encounter both familiar and novel ethical issues and dilemmas in their professional practice. They will not be able to rely on memorized facts to deal with novel situations, but will need skills in logical use of factual information, perspective taking, application of relevant theory, and high quality decision making, all of which are aspects of ethical decision making. They may need to agree with others who have different opinions about a plan of action for a given ethical problem. Because structured controversy promotes development of these skills and also provides a model for addressing a dilemma, it serves as a rehearsal for dealing with future ethical problems.

The issue of whether to give or withhold nutrition and hydration by artificial means was chosen because it raises important ethical concerns that have growing social significance as health-care technology continues to make more therapy options available. Based on the students' performance on previous ethics assignments, this issue was judged to be appropriate for them in view of their levels of cognitive and moral reasoning.

Preparation of Class Materials

A handout containing several items was developed by faculty for this class and was distributed at the beginning of the quarter along with other course materials. One item was the unit syllabus for the Ethics MCSL in this course, which included the ethics course and unit objectives and assigned readings (American Nurses' Association Committee on Ethics, 1988; Cohen, 1988; The Hastings Center Guidelines, 1987; Siegler & Weisbard, 1985; Steinbrook & Lo, 1988).

A second item, "Plan for Structured Controversy" (Fig 1), stated the question to be discussed, the brief case situation, and the objectives for the class, and a list of factors that might be considered during the controversy (e.g., ethical principles, formal codes, and professional guidelines). The third item, "Schedule for Structured Controversy" (Fig 2), was slightly modified from models previously published (Johnson & Johnson, 1988; Johnson, Johnson & Smith, 1986; Smith, 1984). This page restated the question to be discussed, described briefly each step in the structured controversy process, and gave the time allocation for each step. A fourth item, "Structured Controversy Discussion Format," elaborated on what should be done during each step of the controversy process. The last step of the controversy process was to be a group report of conclusions reached by the group. Therefore, a fifth item included in the handout was the "Criteria for Evaluation of Group Report" (Fig 3).

As these materials were distributed to students a few weeks prior to the structured controversy class, students

Should nutrition and/or hydration be withheld in the described situation?
To answer the assigned question, please follow the schedule below. Assign one member to be the time keeper.

INTRODUCTION (5 minutes)
- Number yourselves from 1 to 4.
- Initially, the odd numbered persons will take the "for" perspective and the even numbered persons will take the "against" perspective
- Review procedures to be followed.

ASSIGNED PERSPECTIVE (25 minutes)
- Prepare presentation with partner (10 minutes).
- Present arguments (5 minutes for each side; 10 minute total). Ask clarification questions when the opposite side finishes presenting.
- General discussion (5 minutes).

REVERSE PERSPECTIVES (20 minutes)
- Prepare presentation with partner (10 minutes).
- Present arguments (5 minutes for each side; 10 minutes total).

OPEN DISCUSSION, DECISION MAKING (15 minutes)
- Drop perspectives.
- Seek and provide clarification, elaboration, justification, and rationale.
- Summarize arguments.
- Reach conclusions.

REPORT PREPARATION (25 minutes)
- Prepare your written response to this question, including rationale. Refer to Criteria for Evaluation of Group Report. Submit this response to an instructor before leaving class.

Figure 2: Schedule for structured controversy.

were given a verbal explanation of structured controversy and the anticipated benefits when using it with this issue, and were given an opportunity to ask questions for clarification. In this way, faculty used these materials as an advance organizer and sought to motivate students to conscientiously prepare for structured controversy by reading about the issue so that they could argue their positions effectively, based on facts.

Forming Heterogeneous Groups

Students were given their assignment to groups 1 week prior to the structured controversy class to facilitate their moving into groups quickly on the day of structured controversy. Assignment to groups was based on students' responses to a survey item 3 weeks prior to this class. This item was embedded in a survey concerning controversial issues in health care. Students had responded to the statement "When a patient is comatose with no hope of recovery, the patient's family and physician have the right to withhold nutrition and hydration from that patient until that patient dies," using a 7-point Likert scale ranging from "strongly disagree" to "strongly agree." To make groups as heterogeneous as possible, students were distributed so that each group was comprised of two students who had indicated opposite responses (e.g., 1 and 7,or 2 and 6), one who had chosen "4," and one other student. Also, each of the eight male students was placed in a different group, as was each of the 11 RN students.

Room Arrangement

Because the large auditorium in which class sessions for this course were normally held was not suitable for group work, a nearby large classroom with movable chairs was reserved for the structured controversy class period. Chairs were arranged in groups of four. Each grouping of chairs was identified with a large number (1 through 12) so that students could easily find the group to which they had been assigned. The arrangement of chairs allowed maximum space between groups, to provide a buffer against the noise of students' vigorous arguments.

Beginning Structured Controversy

At the beginning of the controversy session, students within each small group numbered themselves from one to four. The odd numbered students were told to begin the controversy by arguing "yes" to the stated question (Should nutrition and hydration be withheld. . .?) and the even numbered students were told to begin by arguing "no" to the question. Students arguing "yes" were asked to wear a green paper tag with "give nutrition and hydration" printed on it and those arguing "no" were asked to wear a yellow paper tag with "withhold nutrition and hydration" printed on it. These tags were concrete reminders to students of the position they were arguing and who comprised a team. Tags were an effective reminder to reverse positions when students exchanged tags with their opponents and to drop advocacy of a position when they removed their tags. Writing paper was provided for students to take notes during their arguments to use when they reversed perspectives, and to write the small group's conclusions and rationale after a consensus had been reached.

1. **Conclusions are clearly presented.**
   1.1 Conclusions are written in a legible and grammatically correct manner.
   1.2 Conclusions are written so there is a logical flow of ideas.
2. **Conclusions are strongly supported by rationale.**
   1.1 There is a logical connection between rationale presented and conclusions.
   1.2 The rationale presented is credible.
   1.3 Some or all of the following are cited as part of rationale:
   assigned readings for this class;
   ethical principles and/or theories; and/or
   professional codes and/or guidelines.
   1.6 Weaknesses in counter-arguments to conclusions reached are highlighted.

Figure 3: Criteria for evaluation of group report.

Progress Through Structured Controversy

The schedule to be followed and the specific position that students were to argue for and against were written on two chalkboards in this classroom to serve as readily available reminders to students. As the students progressed through the schedule of structured controversy, faculty circulated among the small groups of students as observers of discussion, facilitators of discussion if a group became locked into arguments they were unable to resolve, and timekeepers to keep students progressing through the schedule.

Small Group Reports and Evaluation

Students prepared a written group report that was graded according to the criteria listed in Fig 3. After the group reports had been evaluated, students received photocopies of their group's graded report and a memo giving feedback about the group reports in general to further enhance their learning. The memo highlighted the important points made by the various groups (see points 1 to 6 below.) No one paper covered all of these points, nor was that necessary to achieve a high score since the time allotted for preparation of group reports was limited. Some faculty commentary [in brackets] was included in the memo to clarify and expand important points.

1. A critical decision point has been reached in this situation and this needs to be acknowledged by the parties involved (e.g. nurses, family, nursing assistants, physicians);
2. Giving nutrition and hydration by artificial means was favored by some groups and some favored withholding. A few groups did not say whether or not the group took a position about withholding or giving. In these cases, the conclusions presented all focused on who should make the decision and how it should be made. [Various parties involved (e.g., parents, nurses, physicians) might reach different morally defensible decisions about whether or not to give nutrition and hydration by artificial means. Conclusions were evaluated, not according to the position taken to give or withhold nutrition and hydration, but according to how logically conclusions were supported using ethical principles and theories, professional codes and guidelines, and other relevant, factual information.]
3. Who should decide is a critical issue in this case. [Faculty hoped that each group would reach a decision about what the group as health providers thought should be done (if it were the group's decision to make). Yet faculty hoped each group would wrestle with who should decide.] Several reports stressed, and documented from the readings, that the patient first and foremost has the right to decide, based on the principle of autonomy or individual freedom. Some reports directly addressed the issue of whether or not Sara Olsen had decision making capacity at the point in time described. Some acknowledged that the patient may or may not have indicated her wishes while competent. Some specifically addressed the role of advanced directives (verbal or living will) or surrogate decision making.

   Some went on to state that, if the patient never indicated her wishes, her parents, then, have the right to decide unless some other surrogate decision maker was designated by the patient while she had decision making capacity. Some made the point that, even if the patient had not made a clear statement about her wishes, the parents might be able to infer them from their close association with their daughter. In that case, it would be their duty to decide what they thought the daughter would want if she were capable of deciding, even if their personal decision would be different. It was pointed out by some that the family might not know or be able to infer the daughter's decision and might not be sure of their own decision. [In that event, they might seek ethical guidance from clergy, the nurse, or other health team members.]
4. A major issue that several groups addressed well was how to do the decision making if the preference of the patient was not clear cut (e.g., no advance directive). Several variations of team conferences were suggested that included some or all of the key parties (e.g., parents, nurse, physicians). Some groups proposed the use of an ethics committee.
5. One group strongly stressed that for the health providers to make the decision for the family would be paternalistic. [This does not, however, mean that the health providers should not advise the family if they are asked or if the family clearly has no idea what to do.

This is one reason it is important for students to decide what they would do if it were their decision to make. Hopefully, a nurse would not just say "I think you should..." but would provide the family with enough information and support that they could reach a decision. In some situations, family members might like to know what guidelines have been issued by groups such as the Hastings Center, the American Nurses' Association, and the American Medical Association, and might appreciate help in seeing how the guidelines apply to their situation. It would also be important to let an indecisive family know that some health providers, ethicists, and clergy have thoughtfully questioned the conclusions presented in the formal guidelines mentioned earlier.]

6. Some groups mentioned that feeding by artificial means would cause the patient pain or "burden" that would not be outweighed by the benefits. Some groups said that lack of food and fluids would cause emaciation and dehydration and those would be painful to the patient. [In the published literature and among health-care workers who have worked extensively with dying patients, there is no consensus about what a patient such as the one described actually feels and experiences either when nutrition and hydration are given by artificial means or when they are withheld. Some writers and clinicians have addressed undesirable consequences that may occur when a person who is physiologically dying is given fluid and hydration artificially (e.g., lack of gastrointestinal motility and ability to absorb nutrients or increased motility with diarrhea). Others stress discomfort such as that assumed to be associated with dry mucous membranes.] One group made the distinction between supplying complete nutrition and hydration artificially and providing a limited amount of hydration and nutrition simply as a comfort measure.

The memo went on to note that the following points were omitted from group reports.

1. What morally defensible action(s) the nurse could take if the patient or family made a decision to either give or not give hydration and nutrition that the nurse ethically could not support and help implement is an issue that was not addressed. [The assigned readings did speak to this issue.]
2. No group considered the issue that could arise if the patient had clearly made her wishes known while competent, but the parents did not agree with the daughter's decision.

Student Evaluation of this Experience

Responses on course evaluations showed that not all students were enthusiastic about their first experience with structured controversy. This was somewhat surprising since small group reports had illustrated the point that through structured controversy students could effectively identify critical points about the situation and view it from multiple perspectives. However, it was obvious to faculty during the structured controversy class that some groups were having more provocative and in-depth discussions than others. Some groups clearly had one or more members who had come to the class poorly prepared and seemed unmotivated to make the most of the class time. Apparently, some students have become conditioned to an educational system that has treated them as passive recipients of information. Thus, it appears that faculty members must help students make the transition from passive learning to interactive learning. Students also must be encouraged to take responsibility for preparing for class and for contributing to their own and their peer's classroom learning. Given the strength of the research findings that demonstrate the benefits of interactive learning experiences, continued heavy reliance on didactic teaching methodologies would rob students of much-needed opportunities to develop optimally and would be an abdication of responsibility by both teachers and learners.

Summary

With the expanded use of technological advances in health care accompanied by the need for moral decisions, there is a growing pressure on nurses to be proficient in ethical decision making. Development of skills central to ethical decision making can be promoted through use of structured controversy as a learning strategy.

Although this article describes the use of structured controversy with undergraduate nursing students, this learning strategy could also be used effectively with other populations including graduate students, nursing faculty, and staff nurses. Additional structured controversies have been developed and implemented with nursing students regarding selected aspects of AIDS and rational suicide (Pederson, unpublished). Other controversial issues in health care that have a strong ethical component and would also be appropriate to address using structured controversy include abortion, eligibility for organ transplants, and the allocation of scarce health-care resources. Nurses' ability to take others' perspectives accurately, engage in high quality problem solving, and reach ethical decisions will enhance the professional nursing care they provide, thus benefiting their clients and, through them, the community in which they practice nursing.

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Teaching Ethics In Professional Education

By Laura Duckett, Muriel Ryden, Mary Ellen Waithe, Kathy Schmitz, Arthur Caplan, and Patricia Crisham

Commenting on the effect the turbulent changes in American life have had on moral education, Harvard president Derek Bok concludes: "If other sources of ethical values have declined in influence, educators have a responsibility to contribute in any way they can to the moral development of their students."[1]

In colleges and universities in the United States today, every department faces the challenge of teaching ethics effectively. Because ethical conduct by professional practitioners is so important, professional schools are particularly challenged to incorporate ethics into their programs.

In the baccalaureate nursing program at the University of Minnesota, our ultimate goal has been "not to impart 'right answers' but to make students more perceptive in detecting ethical problems when they arise, better acquainted with the best moral thought that has accumulated through the ages, and more equipped to reason about the ethical issues they will face in their own personal and professional lives."[2] Our more concrete immediate goal has been to systematically integrate ethics into a highly structured nursing curriculum.

Both goals seem relevant across the boundaries of professional disciplines. Indeed, though it was designed for nursing, the model we used for integrating ethics into our curriculum is clearly relevant for integrating ethics into other tightly packed curricula.

Advances in technology—and wrenching social problems—are presenting health professionals

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With ethics becoming so important a part of professional education, faculty must find ways to teach it within curricula already bulging at the seams.

with many ethical issues. Medical breakthroughs such as organ transplants and assisted reproduction raise troubling ethical questions, as do drug abuse, teenage pregnancy, and the public-health crisis brought on by AIDS. The urgent need to contain health care costs is forcing health professionals to make difficult decisions about allocating resources.

These emerging concerns add to the already full plate of ethical issues that health professionals face in their day-to-day care of patients. With ethics becoming so important a part of professional education, faculty must find ways to teach it within professional programs. In nursing, this challenges educators to expand curricula already bulging at the seams.

Should we delete existing requirements—in a discipline where knowledge basic to professional practice is rapidly increasing? Should we decrease the liberal arts requirements—at a time when some nursing programs are moving to post-baccalaureate entry-to-practice based on a four-year liberal arts education? With society desperately short of nurses, should we increase nursing credits and risk losing students?

In the past, integrating concepts or content rather than adding courses has often meant that presentation is scattered, disorganized, incomplete, or duplicated. The emphasis new concepts get, and the competence with which they are addressed, are likely to depend on the expertise and interest of the faculty teaching these concepts and the courses in which they are integrated. What is supposed to be "integrated in" may actually be "integrated out." To avoid these pitfalls, we employed "multi-course sequential learning" (MCSL) at Minnesota.

MCSL—pronounced "muscle"—weaves a strong content fiber through a program's various levels. Rather than a single, discrete course, students experience a vertical course spanning the program. Imbedded in existing courses, MCSL units provide the equivalent of a credit-bearing course without actually adding one. As an added benefit, working a MCSL into the program provides the impetus for critically evaluating and streamlining existing courses.

Implementing multi-course sequential learning characteristically includes a precise defining of the MCSL content and a careful sequencing of that content from course to course so as to provide a

In some courses, the existing course content is reframed to make its connection to ethics explicit, something that requires no additional class time.

good fit with student development and to build on previous learning. Student learning in the MCSL must be evaluated and defined faculty made responsible and accountable for the MCSL.[3]

At Minnesota, the MCSL we constructed to integrate ethics into the upper-division nursing curriculum includes core units in six classroom courses and a conference on ethics in each clinical course. In several additional courses, the existing course content is reframed to make that content's connection to ethics explicit, something that requires no additional class time.

Before the MCSL, ethics content was being taught, but was not labeled ethics or even necessarily considered to be ethics. In skills courses, for instance, the importance of respecting patient privacy, giving accurate information, and having the patient agree before carrying out a nursing activity were all stressed as "good nursing practice." But the link to autonomy, truth telling, and other basic ethical principles was not made explicit.

Multi-course sequential learning provides a *structural* model for integrating a particular content area into a curriculum. For a *process* model for teaching ethics, we have found direction and coherence in the "four-component model" for moral action developed by Rest,[4] which has been utilized in teaching dental ethics[5] (see figure 1). To stimulate student inquiry, we have developed questions to accompany Rest's components.

At the beginning of the nursing program, we emphasize moral sensitivity in clinical situations. Then, as students are introduced to ethical principles and theories, they gain moral knowledge and practice the critical thinking needed to carry out moral reasoning. As students approach the latter half of the program, increasing attention is given to examining the factors that influence commitment to taking moral action and developing the skills necessary for effective moral agency (see appendix).

The ethics MCSL lends itself to a variety of teaching strategies. We prefer interactive methods that challenge students to grapple with ethical problems. For example, students working in small groups to create a model of *their conception* of how the components of an ethical action fit together. We also use case analysis, structured controversy,[7] perspective taking,[8] and journal writing. Sources for case studies include

Figure 1

Questions to Stimulate Ethical Analysis Derived from Rest's Four-Component Model of Moral Behavior (Rest, 1982; 1986)

Component 1—Moral Sensitivity (Realizing there is a moral problem)

1. Who are the parties in this situation?
2. Who is affected by this, and how?
3. Which ethical principles are in conflict?
4. Whose rights/duties/values are in conflict, and what are those rights/duties/values?
5. What are the possible actions and the potential consequences of each?

Component 2—Moral Reasoning (Deciding what is the right thing to do)

1. How do you weigh conflicts among rights, duties, principles, or values?
2. Is it more important to preserve or protect some rights/duties/principles/values over others? Why or why not?
3. Considering all of the above, morally speaking, what ought the nurse to do?

Component 3—Commitment (giving priority to moral values over other competing values)

1. Suppose you were really in this situation. Do you believe you would do what you said the nurse ought to do?
2. Would you still be able to do this, given any possible negative consequence to yourself (including the loss of potential benefits from some other course of action)?
3. What specific personal negative consequences might prevent or limit your acting as you say the nurse should?

Component 4—Implementation (Taking moral action)

1. Given that there may be many ways to carry out a moral decision, what methods might limit potential negative consequences?
2. How might you speak to the parties involved? What might you say?
3. What interpersonal skills are most likely to enhance your ability to carry out the action you have decided upon?
4. What kinds of objections might be raised to your decisions? How can you explain your decision in a way that addresses those objections?
5. What will you *actually* say and do?

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contemporary news reports and the clinical experiences of faculty and students. Analysis, preferably in small groups, follows the questions in figure 1. In structured controversy, conflict is presented in a way that allows students within small groups to argue for and against a specific position on a disputed issue, then attempt to reach a consensus.

To practice taking perspectives—putting themselves in someone else's shoes—students simulate a hospital care conference, acting out the roles of patient, family members, and health care providers, all with varying points of view on an ethical issue. This perspective taking can increase moral sensitivity. Afterwards, students discuss and analyze the experience with faculty and peers.

We also ask students to keep a journal describing experiences they have clinically and as college students which have ethical implications. Again using the questions in figure 1, the students analyze one of these situations. Ethics faculty discuss the journals individually with each student.

Strategically placed lectures are

Similarly, introductory courses in journalism might explore the handling of conflicts between the source's right to privacy and the public's need to know.

given by experts drawn from the university community such as moral philosophers, bioethicists, nurse ethicists, and nurse lawyers. Such lectures are used sparingly, accompanied by discussion among students and faculty.

The flexibility of the ethics MCSL was demonstrated when, after two years of implementation of the ethics MCSL, our undergraduate curriculum was changed from a three-year program, with entry as sophomores, to an upper-division curriculum. Despite major changes in the way nursing content was organized and delivered, the ethics units transferred with relative. ease from the old curriculum to the new.

We believe that the MCSL model is transferable to the education of other professionals.

Students entering professional programs usually harbor preconceived views about both the practice and the values of the profession. Introductory courses in the history of the profession are frequently the first opportunity to instruct students in the profession's practice and values and the logical place to introduce ethics without significantly altering course content.

At Minnesota, we introduce ethics in just such an introductory course. Caring has always been the central value of nursing, but, in the past, the context was obedience and loyalty to the employing institution, which has often been hierarchical—the church or the military, for instance.

In contrast, the emphasis now emerging in nursing is on critical thinking, independent decision making, patient advocacy, and accountability. The ethics MCSL links these concepts to principles of individual autonomy, respect for persons, justice, truth telling, and sanctity of life.

Similarly, introductory courses in journalism might explore the historical handling of conflicts between sources' right to privacy and the public's need for news based on reliable information from credible sources. Likewise, journalism students could be challenged to explore whether the public's right to know is ever in conflict with the public good. Might uncensored reporting of the Chernobyl nuclear accident, for instance, have led to a panic mass exodus and many more deaths?

Once introductory courses have provided fundamental knowledge about ethics, ethics units in each subsequent course can be made relevant to the focus

of that course. In nursing, students in a critical-care course deal with such issues as how aggressively to treat and how to respect autonomy in the face of a high-tech environment controlled by health care providers. Similarly, a course in computer science might explore how client, employee, and competitor interests in privacy and secrecy can be balanced against economic and production needs to interface systems.

In business administration, students might be challenged to weigh economic and social concerns in a classroom course covering quality control. Personnel management courses might explore whether employers in a difficult economic climate have the responsibility to hire handicapped workers. Industrial development and planning programs might assess what responsibilities large employers have to small towns where they provide the economic l ne.

In professional field work, practica, or clinical courses, students can grapple with the real-world application of ethical knowledge. Here, it is less feasible to bring in faculty with expertise in the ethics of the profession. Instead, the faculty responsible for the courses must teach ethics themselves.

Indeed, the faculty-development component of our MCSL has made those teaching nursing better able to help their students use clinical experiences to enhance their moral sensitivity and reasoning, and to support students in taking moral action.[9] This teaching and support often takes place in clinical conferences devoted to discussing the issues that arise out of concrete student experience, as well as one-to-one discussions between student and faculty.

Teaching ethics through field work allows emphasis on ethics with a little "e," the everyday situations that call for moral behavior. Students face the reality that, although the big "E" dilemmas are the ones that make the headlines, ethics permeates their professional lives in more subtle and persistent ways. ■

Notes

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[5] M.J. Bebeau, "Teaching Ethics in Dentistry," *Journal of Dental Education*, 49(4) (1985), 236-243.

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[8] M.B. Ryden, L. Duckett, K. Schmitz, and M.E. Waithe, "Stimulating Ethical Sensitivity and Moral Reasoning through Perspective Taking," (1989), manuscript in progress.

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Appendix

Ethics Curriculum Overview—Junior Year

Courses	Ethical Content
QUARTER 1	
Core Concepts in Nursing *(Credits: 4; MCSL: 4 hrs.)*	• Historical context for nursing ethics • Values of the nursing profession • Ethical principles • Components of ethical decision making • Comparison of ethical decision-making process and nursing process
Practicum: Laboratory and Ill Adults *(Credits: 3; MCSL: Augmentation)*	• Situations involving ethics with a small "e" • respect, confidentiality
QUARTER 2	
Restoration and Enhancement of Health I *(Credits: 4; MCSL: 4 hrs.)*	• Overview of ethical theories • Interface of ethical and legal components • Informed consent
Practicum: Acutely Ill Adults *(Credits: 7; MCSL: 1 clinical conference)*	• Paternalism • Deception
Interpersonal Communications (IPC) *(Credits: 2; MCSL: Augmentation)*	• Augmentation links genuiness, empathy, and eliciting the perspective of others with ethical principles
QUARTER 3	
Restoration and Enhancement of Health *(Credits: 4; MCSL: 4 hrs.)*	• Definition of death • Benefit vs. burden • Aggressive vs. limited treatment • Advanced directives • Proxy decision making & substituted judgment • Active & Passive euthansia
Practicum: Acutely ill Children & Aged *(Credits: 8; MCSL: 2 clinical conferences)*	• Ethical issues commonly faced with hospitalized children and aged clients • Parents vs. children's rights
Advanced IPC *(Credits: 2; MCSL: Augmentation)*	• Augmentation focuses on mutuality with and respect for dysfunctional communicators

Appendix (continued)

Ethics Curriculum Overview—Senior Year

Courses	Ethical Content
QUARTER 4	
Core Concepts in Critical Care *(Credits: 5; MCSL: 4 hrs.)*	• Application of previous content to critical care situations • Role of ethics committee • Ethical and legal aspects of organ transplantation and autopsies
Practicum: Critically Ill Infants, Children or Adults *(Credits: 8; MCSL: 1 clinical conference)*	• Just allocation of critical care beds, high tech treatment, intensive nursing care, societal resources • Rights of patient & family to family-centered critical care
QUARTER 5	
Core Concepts in Community Health & Long Term Care *(Credits: 4; MCSL: 4 hrs.)*	• Social Justice • Allocation of community, state, national resources • Filial obligations: rights of adult children vs. dependent parents • Conflicts between rights/needs of family member with chronic illness and other family members • Conflicts between autonomy and beneficence in long-term care • Abuse of children and vulnerable adults • Rights & obligations of clients with respect to their own health enhancement, disease prevention, and early detection and treatment
Health Assesament *(Credits: 3; MCSL: Augmentation)*	• Ethical issues related to obtaining a health history & physiological data base
QUARTERS 5-6	
Practicum: Families with children *(Credits: 8; MCSL: 2 clinical conferences)*	• What is commitment and how does it influence moral action • Fetal/maternal rights and well being
QUARTER 6	
Leadership/Followership Management *(Credits: 4; MCSL: Augmentation)*	• Augmentation accentuates skills needed to take ethical action: e.g., assertiveness, planned change, conflict resolution
QUARTERS 6-7	
Practicum: Individual, Groups, Populations in the Community & Psychiatric Settings *(Credits: 10; MCSL: 2 clinical conferences)*	• Ethical issues commonly faced in enhancing health and with psychiatric clients • Upholding autonomy to extent possible despite limitations in mental and/or physical health
QUARTER 7	
Applied Clinical Research *(Credits: 3; MCSL: 4 hrs.)*	• Informed consent for research • Protection of human subjects • Ethical conduct of research and reporting of research findings
Professional Issues *(Credits: 2; MCSL: 2 hrs.)*	• Ethical aspects of major professional issues

*All credits are quarter hour credits

APPENDIX B

ETHICS CONTENT IN THE CURRICULUM

Table 1

THE ETHICS MCSL IN THE REVISED UNDERGRADUATE CURRICULUM

LEVEL I

FALL QUARTER

NURS 5000 Core Concepts (four 50 minute hours)

Class 1 (two 50 minute hours) Ethical Principles and Values

Objectives:
1. Clarify personal beliefs and values, relating them to a developing philosophy of nursing.
2. Describe a rationale for viewing ethical problems as a nursing responsibility.
3. Describe how moral sensitivity, moral reasoning, and commitment relate to moral action.
4. Apply the "universal ethical principles" as proposed by Thiroux to the Cruzan case.

Advance Assignment:
Curtin, L. (1982). The commitment of nursing. In L. Curtin & M.J. Flaherty (Eds.), Nursing ethics, theories, and pragmatics (pp. 97-102). Bowie, MD: Robert J. Brady Co.
Thiroux, J. (1986). Setting up a moral system: Basic assumptions and basic principles. In Ethics theory and practice (pp. 118-148). New York: MacMillan Publishing Co.
Handout: Ethical Principles and Values (objectives and study questions).

Description of learning activities:
Introduction to Ethics MCSL and relationship of ethics to prior course content.
Introduction to Rest's Four Component Model. Distribute handout during class.
Summary of universal ethical principles as described by Thiroux.
Viewing videotape of Cruzan case and discussion of case in terms of ethical principles and personal values.

Evaluation:
Three take-home examination questions, related to a case situation, that cover ethical principles, the ANA Code for Nurses, the Patients' Bill of Rights, and the School of Nursing Philosophy.

Class 2 (2 class hours) Interrelationships among Components of Ethical Action

Objectives:
1. Construct a conceptual model depicting the interrelationships of the components of ethical analysis of nursing situations.
2. Relate a process for decision making in nursing to a process for ethical decision making.

Advance Assignment:
Handout: Components of a Model for Ethical Analysis of Nursing Situations
See homework assignment below.

Description of learning activities:
Students do the model building homework activity, as described in the MCSL Building Handbook

(Supplemental 1), pp. S-6 - S-8.
Students do the model building group activity, as described in the MCSL Building Handbook (Supplemental 1), pp. S-9.

Evaluation:
Ethics MCSL faculty collect models and determine whether the assignment was done completely. Faculty teaching course are notified regarding whether each student completed the assignment.

NURS 5021 Practicum: Ill Adults

No ethics hours or augmentation. Faculty teaching course are encouraged to reinforce ethics

WINTER QUARTER

NURS 5040 Restoration/Enhancement of Health: Acutely Ill Adult (four 50 minute hours)

Class 1 (two 50 minute hours) Introduction to Ethical Theories

Objectives:
1. Describe the essential characteristics of rule-based and consequentialist moral theories.
2. Describe the characteristics and varieties of virtue theories.
3. Identify the characteristics of utilitarianism and distinguish rule utilitarianism from act utilitarianism.
4. Identify the variety of origins of duty based theories and give examples of each.
5. Identify the characteristics of the rights theories of Plato, Kant, and Rawls.
6. Identify the limitations of virtue ethics, utilitarianism, duty ethics and rights theories.
7. Describe how virtue ethics, utilitarianism, duty ethics and rights theories apply to nursing practice.
8. Describe the skill of moral intuitionism.
9. Contrast key aspects of the following ethical theories: virtue, right, duty, and utilitarianism.

Advance Assignment:
Handout of objectives
Benjamin, M. & Curtis, J. (1986). Unavoidable topics in ethical theory. Ethics in nursing (pp. 26-50). New York: Oxford University Press.
Waithe, M.E. (1990). Summary of moral theories. University of Minnesota.

Description of learning activities:
Case-based lecture/discussion by a philosopher who will assist students in understanding the meaning of concepts from the readings in relation to a clinical situation.

Evaluation:
Two take-home examination questions, related to a case situation, that cover ethical theories.

Class 2 (two 50 minute hours)
Paternalism and Informed Consent: Ethical and Legal Perspectives

Objectives:
1. Describe the essential criteria for informed consent to treatment.
2. Discuss the role of the nurse regarding informed consent to treatment.

3. Distinguish between decisional capacity and competence.
4. Contrast rational persuasion, manipulation, and coercion as ways of getting clients to pursue health goals.
5. Describe paternalism as a conflict between ethical principles.
6. Given a situation involving paternalism, describe how the situation could be handled in a non-paternalistic or less paternalistic way.
7. Describe characteristics of acute care environments that affect the autonomy of clients and nurses.
8. Discuss the legal responsibilities of the nurse to individual clients.
9. Describe key differences, similarities and interface between law and ethics.

Advance Assignment:
Handout of objectives.

Benjamin, M., & Curtis, J. (1986). Nurses and clients. In Ethics in nursing. New York: Oxford University Press, 51-79.

Drane, J. (1985). The many faces of competency. The Hastings Center Report, 15(2), 17-20.

Kjervik, D. (1990). The connection between law and ethics. Journal of Professional Nursing, 6(3), 138, 185.

Lynn, J. (1983). Informed consent: An overview. Behavioral Sciences and the Law, 1(4),29-45.

Description of learning activities:
A presentation by a nurse-attorney and a nurse-ethicist of the similarities, differences and interface between the law and ethics, particularly in relation to issues of informed consent, competency, decisional capacity, and paternalism.

Show selected segments of "Dax's Case" (about 30 minutes), which depicts a severely burned patient who futilely attempts to assert his autonomy by refusing treatment.
Use the videotape as a stimulus for discussion of the issues identified in the objectives. Raise the questions, "What should the nurse do in this situation? Why?"

Evaluation:
Approximately 4 multiple choice questions on the course final exam.

NURS 5041 Practicum: Ill Adult (one 50 minute clinical conference)
Developing Awareness of Ethical Issues in Clinical Practice

Objectives:
1. Increase awareness of the ethical aspects of clinical nursing.
2. Appreciate the need for accurate clinical information on which to base ethical decision making.
3. Use ethical principles and theories in analyzing actual clinical experiences where ethics is a concern.

Advance Assignment:
Students are required to record in their clinical journals at least two experiences they have had in clinical when they were aware of an ethical issue. They are asked to photocopy these examples and turn the copy in to their clinical instructor prior to the clinical conference.

Description of learning activities:
One of the Ethics MCSL faculty member and the clinical instructor lead a clinical conference that focuses on some of the situations from the students' journals. (The clinical instructor and Ethics MCSL faculty member read the situations the students' journals prior to the clinical conference.) Questions related to Component 1, ethical sensitivity, and Component 2, moral reasoning, of the Rest Four Component Model of Ethical Action are used as a framework for discussing the situations described by the students' in their journals.

Evaluation:
There is no formal evaluation of this experience.

NURS 5042 Interpersonal Communication I (two 50 minute hours)

Objectives:
1. Describe possible consequences of the use of deception in health care.
2. Use ethical principles and theories in reasoning about specific ethical concerns.
3. Identify factors that facilitate or impede the taking of moral action in support of an ethical position.
4. Describe the influence of interpersonal communication skills on interdisciplinary ethical decision making.
5. Appreciate how an ethics committee can serve as a resource for health care professionals.

Advance Assignment:
Bok, S. (1978). Lies to the Sick and Dying. Lying: Moral choice in public and private life. New York: Pantheon Books, pp. 220-241.

Description of learning activities:
Show the videotape, "Deception," which portrays a physician-nurse conflict regarding the issue of deception. Routine blood tests on a 66 year old woman who is hospitalized following an automobile accident reveal that she has latent syphilis. Her husband was critically injured in the accident. The primary nurse is assertive in disagreeing with the physician regarding his plan to treat the patient without telling her. The physician and nurse take their concerns to the hospital Ethics Committee, which wrestles with the complex ethical and legal issues embedded in the case.

Use the videotape as a stimulus for discussion of the issues identified in the objectives. Use handout that includes the objectives and 13 discussion questions related to the case. The first 8 questions are based on the Rest Four Component Model and the remaining 5 are summary questions.

Distribution of the handout, "Illustration of the Application of Ethical Principles in Caring for Clients - Level I". This handout makes clear how skillfully implementing specific interpersonal and psychomotor skills upholds specific ethical principles.

Evaluation:
There is no formal evaluation of this experience.

SPRING QUARTER

NURS 5140 Restoration/Enhancement of Health: Children and Elderly (four 50 minute hours)

Class 1 (two 50 minute hours) Aggressive Versus Limited Treatment

Objectives:

1. Examine the process of making treatment decisions for patients who lack decision making capacity.
2. Analyze current practices and precedents regarding advanced directives, proxy decision making and substituted judgment in terms of the principle of autonomy.
3. Describe use of the concept of relative benefit versus burden in decision making about limiting treatment.
4. Differentiate between decisions not to resuscitate and other decisions to limit treatment.

Advance Assignment:

Macklin, R. (1986). Consent, coercion and the conflict of rights. In T. Mappes & J. Zembaty (Eds.), Biomedical ethics, (2nd ed.) (pp. 345-354). New York: McGraw-Hill.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1983). Patients who lack decision making capacity. In Deciding to forego life-sustaining treatment (pp. 121-153). Washington, DC: U.S. Government Printing Office.

Description of learning activities:

Informal lecture by a bioethicist (Art Caplan, Ph.D.) who uses case situations to involve students in discussion the issues inherent in decisions about limiting treatment.

Evaluation:

Approximately 4 multiple choice questions on the course final exam.

Class 2 (two 50 minute hours) To Give Or Not to Give Nutrition and/or Hydration by Artificial Means to a Terminally Ill Patient

Objectives:

1. Given a simulated case involving a patient for whom there is no hope of recovery:
   a. present arguments for and against initiating nutrition and/or hydration by artificial means;
   b. critique the validity of the arguments presented by others;
   c. defend your own position, against the critique of others, using rationale based on ethical principles and theories, law, nursing and medical knowledge, and other relevant considerations; and
   d. prepare a written summary of conclusions reached by the group, and/or by individual members of the group, including rationale(s) for conclusion(s).
2. Analyze personal feelings and attitudes that might arise if you were to be assigned to care for a patient and family where:
   a. there is no hope that the patient will recover or improve; and
   b. withholding or withdrawing nutrition and/or hydration might be considered.

Advance Assignment:
Advance handouts that describe the learning strategy to be used in class, MCSL Building Handbook (Supplemental 5), pp. S-25 - S-29.

ANA Committee on Ethics. (1988). Guidelines on Withdrawing or Withholding Food and Fluid. Kansas City, MO: American Nurses' Association.

The Hastings Center. (1987). Guidelines on the termination of life-sustaining treatment and the care of the dying. Briar Cliff Manor, NY: The Hastings Center, 18-34; 59-62.

Cohen, C.B. (Ed.). (1988). Casebook on the termination of life-sustaining treatment and the care of the dying. Briar Cliff Manor, NY: The Hastings Center.
Chapter 12. "No patient of mine will ever starve to death! The case of Mrs. Franklin." Commentary by L.K. Evans, 59-64.

Siegler, M., & Weisbard, A.J. (1985). Against the emerging stream: Should fluids and nutritional support be discontinued? Archives of Internal Medicine, 145, 129-131.

Steinbrook, R., & Lo, B. (1988). Artificial feeding--Solid ground, not a slippery slope. The New England Journal of Medicine, 318(5), 286-290.

Description of learning activities:
Students do the structured controversy described in the MCSL Building Handbook (Supplemental 5), pp. S-22 - S-29.

Evaluation:
Each group of 4 to 6 students who engage in a structured controversy prepare a written group report that is graded according to the criteria listed on pp. S-29 of the MCSL Building Handbook.

Feedback:
Each student receives a copy of his/her group's graded report with comments. In addition, students receive a document in which the case is discussed. Students are not given a "correct answer" to the case, but a summary of important points that were made in various group reports, and ways that different groups applied concepts from the assigned readings to the case.

NURS 5141 Practicum: Ill Children (one 50 minute clinical conference)
Ethical Issues in Caring for an Acutely Ill Adolescent

Objectives:
1. Identify the stakeholders in the situation.
2. Determine the range of ethical issues inherent in the case.
3. For selected issues in this case, determine specifically what makes the issue an ethical issue rather than a clinical issue.
4. For at least one issue in this case, reason about what the nurse should do using ethical principles and theories to guide your reasoning.

Description of learning activities:
The stimulus case is about a real, but slightly disguised adolescent, with acute lymphocytic leukemia, who has been admitted to the hospital for treatment that includes a bone marrow transplant. The stimulus senario includes many complex aspects from biomedical, developmental, and psycho-social prespectives. The method used includes: 1) discussing Part I of the case with a partner, using questions that are related to Component 1 of the Rest Four-Component Model; 2) sharing points discussed in pairs with the larger group; and 3) reading Part II of the case and reasoning about what the nurse should do, using ethical principles and theories to guide thinking.

Advance Assignment:
None

Evaluation:
There is no formal evaluation of this experience.

NURS 5142 Advanced Interpersonal Communication II (two 50 minute hours)

Distribution of the *augmentation* handout, "Illustration of the Application of Ethical Principles in Caring for Clients - Advanced". This is a handout that makes clear how skillfully implementing specific advanced interpersonal and advanced psychomotor skills upholds specific ethical principles.

APPENDIX C

MCSL BUILDING: DEVELOPING A STRONG ETHICS CURRICULUM USING MULTI-COURSE SEQUENTIAL LEARNING

Table of Contents

MCSL BUILDING:

DEVELOPING A STRONG ETHICS

CURRICULUM IN NURSING USING

Multi
Course
Sequential
Learning

Edited by:

Laura Duckett, Mary Ellen Waithe, Mary Boyer, Kathleen Schmitz, & Muriel B. Ryden

A Product of the Project:

"Ethics Education for Baccalaureate Nursing Students"

Muriel B. Ryden, PhD, RN & Laura Duckett, PhD, RN

Project Directors

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CONTENTS

APPENDIX D

REPORT OF STUDENT ACHIEVEMENT IN ETHICS

Student ID 228

University of Minnesota
School of Nursing
Report of Ethics Achievement:
Level II - Basic Student

We would like to thank you for your participation in the Ethics MCSL this past year. As promised, we are reporting to you the progress you have made during this year relative to the ethics content. We would also like to remind you that you will not be receiving a separate grade or credit on your transcript for the ethics material. Credit for your work in ethics has been included in the grades for the courses in which the content was presented. This information is for your own self-awareness and growth. At the end of your senior year, we plan to give you a document that states that you have completed the equivalent of a four credit ethics course.

Ethics portion of courses:	Possible points	Your score	low*	high*	mean*
S-408 take-home exam	10	7.0	3	10.0	7.87
S-409 exam questions	3	1	0	2	0.87
S-404 exam questions	2	2	1	2	1.97
S-405 exam questions	2	1	0	2	1.54
S-611 ethics section of chronicity paper	25	23.0	17.0	25.0	21.53
S-611 exam questions	9	9	4	9	6.89
S-613 exam questions	9	7	5	9	7.37
S-407 exam questions**	5	4	2	5	3.31
S-612 structured controversy group report	40	33.0	28.0	37.0	31.85
S-612 ethics section of worksheet	5	5.0	0.0	5.0	4.43
S-614 analysis of journal entry	50	41.0	0.0	48.0	40.72
S-614 exam questions	20	19.0	1.7	19.0	15.32
Total points (unweighted)	180	152.0			

Your % correct of total possible points (unweighted) is 84.44 %.

* Low, high, and mean are the scores for your track

** In S-407 there were ethics sections of the group research proposal and of the research report critique. THese ethics sections were sub-parts of larger sections of these assignments. Separate scores for the ethics sections were not obtained from the course instructor.

Student ID 228

Report of Ethics Achievement:
Level II - Basic Student

Ethics portion of courses:	Possible points	Your score	% of possible points correct	Possible % of course grade	Pts. toward course grade out of 100 possible
S-408 take-home exam	10	7.0	70.00%	10.00%	7.00
S-409 exam questions	3	1	33.33%	1.50%	0.50
S-404 exam questions	2	2	100.00%	1.60%	1.60
S-405 exam questions	2	1	50.00%	1.70%	0.85
S-611 ethics section of chronicity paper	25	23.0	92.00%	8.80%	8.10
S-611 exam questions	9	9	100.00%	3.75%	3.75
S-613 exam questions	9	7	77.78%	2.40%	1.87
S-407 exam questions	5	4	80.00%	2.00%	1.60
S-612 structured controversy group report	40	33.0	82.50%	4.00%	3.30
S-612 ethics section of worksheet	5	5.0	100.00%	1.00%	1.00
S-614 analysis of journal entry	50	41.0	82.00%	5.00%	[illegible]
S-614 exam questions	20	19.0	95.00%	4.00%	[illegible]
Total points (unweighted)	180	152.0			
Total points (weighted)				45.75*	37 **

* The sum of this column is the total weighted points possible.
** The sum of this column is the total weighted points you earned.

Your Level II Ethics MCSL Grade is 81.03%.
This is the percent of the total possible weighted points you earned.

We encourage you to make an appointment with project faculty (Dr. Muriel Ryden or Dr. Laura Duckett) if you wish to discuss this grade report. Ethics Education office is 6-155 Unit F. Phone 624-2492 or leave a message at 624-1100.

APPENDIX E

CURRICULUM EVALUATION PLAN

UNIVERSITY OF MINNESOTA

SCHOOL OF NURSING

UNDERGRADUATE PROGRAM

INFORMATION ABOUT THE PLAN FOR SYSTEMATIC EVALUATION OF STUDENT OUTCOMES OF THE UNDERGRADUATE CURRICULUM

As part of a systematic evaluation of student outcomes of the new upper division undergraduate nursing curriculum, all students entering and completing the program are asked to complete several measures. Faculty teaching clinical courses also are asked to complete several measures related to the clinical performance of students in their sections. The instruments, the variable each measures, the time of assessment, and the person completing the measure are described on the attached sheet, along with rationale for inclusion in the curriculum plan.

We thought that it was important to evaluate clinical performance using the same instrument in all clinical courses to make it possible to average a student's performance across courses. Bondy's (1983; 1984) work provided the idea for using the categories "dependent to independent' as **ratings** of performance. Using her framework, any descriptors of desired performance that are of interest to faculty in a particular school can be used. A group of faculty teaching in the undergraduate program developed the 10 descriptors of clinical performance that we have been using. (See Clinical Evaluation Rating Tool.)

Often, when doing exploratory work, it is helpful to use more than one method of measuring a particular variable. Therefore, in addition to rating each student according to each of the 10 descriptors of clinical performance, faculty are also asked to consider the 10 descriptors as a whole and to **rank** the students in a particular group. For some curriculum evaluation questions, the rankings are likely to be more useful, and for other purposes the ratings are important. A third way of measuring clinical performance is the **Personal Care Preference Rating**. In their work with medical students and residents, Sheehan and colleagues (1980) found that very global measures of overall clinical performance were related to moral reasoning scores, as measured by the Defining Issues Test (DIT). Both the ranking of students within their group as to clinical performance using the 10 clinical performance descriptors and the Personal Care Preference Rating represent our efforts to obtain a "global measure" of overall student clinical performance. We recognize that the Personal Care Rating calls for a subjective rather than objective response. Our hypothesis is that this evaluation by expert teachers who best know the students may reflect a global sense of clinical competence.

These data will enable the School of Nursing to examine the relationship between clinical performance, measured all three ways, and a number of other variables (e.g., outcome variables listed on the chart, age, GPA, ACT scores, and credits completed prior to entering the School of Nursing). Any faculty member who wishes to pose evaluation questions that may be answered using the data that has been and is being gathered is invited to join the committee at a meeting to discuss additional ways of looking at student outcome data.

References:

Bondy, K.N. (1983). Criterion-referenced definitions for rating scales in clinical evaluations. Journal of Nursing Education, 22(9), 376-382.

Bondy, K.N. (1984). Clinical evaluation of student performance: The effects of criteria on accuracy and reliability. Research in Nursing and Health, 7, 25-33.

Sheehan, T.J., Husted, S., Candee, D., Cook, C.D., & Bargen, M. (1980). Moral judgment as a predictor of clinical performance. Evaluation and the Health Professions, 3(4), 393-404.

INSTRUMENT	VARIABLE	TIME	PERSON COMPLETING
Watson-Glaser Critical Thinking Appraisal	critical thinking	entry/exit	student
Measure of Epistomologic Reflection	intellectual development	entry/exit	student
Defining Issues Test	moral reasoning	entry/exit	student
Response to the Student Experience	demographics; perception of program	exit	student
Scale of Humanistic Behavior	aspects of caring	exit	student
Clinical Evaluation Tool Rating	clinical performance	after each clinical course	faculty
Clinical Evaluation Tool Ranking	clinical performance	after each clinical course	faculty
Personal Care Preference Ranking	clinical performance	after each clinical course	faculty

Prepared by:
Committee to Evaluate Student Outcomes of the Undergraduate Curriculum
M. Ryden, K. Krichbaum, M. Miller, and L. Duckett

a:curreval
April 15, 1992