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Nursing education and the ethics of care

Mechelina Thissen

A Thesis

in

The Department

of

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ABSTRACT

Nursing education and the ethics of care

Mechelina Thissen

This thesis examines ethical decision making in nursing. The impact of Kohlberg's theory is contrasted with those of Gilligan, Noddings, Diekelmann, and Benner. The influence of these theorists on nurse researchers to develop their own theories based on nurses' ways of knowing is explored. More specifically the thesis critiques the debate between the "ethic of justice" and "ethic of care". An ethic of care is more congruent with the nature of the nurse-patient relationship and the goals of the nursing profession than previously used paradigms. The thesis contends that nurses respect a fundamental commitment to an ethic of justice in their practice but an ethic of care provides the framework that determines their relationship with their patient. This thesis examines the ethics competency in *Health: Nursing: Program of Study180.A0.*, the new curriculum for nursing programs in Québec, in relationship to the nursing literature on the teaching and learning of ethics. Storytelling, seen as an effective strategy to enhance moral thinking and behaviour, is included as a way to achieve the ethics competency, but its significance could be overlooked if the teacher is not familiar with the literature. A bibliography, which the curriculum does not contain, could remedy this potential problem.

deflection dependence of the PUF stiffness and damping on the vibration isolation effectiveness. Analytical models of the seat-occupant systems are developed by incorporating four different biodynamic human body models, reported in the literature, into the nonlinear seat model. Laboratory experiments are also performed with one subject to experimentally derive the vibration transmissibility characteristics of the seat-occupant system. The analytical response characteristics of the seat-occupant systems are compared with the measured response to assess the validity of the models. The results revealed reasonably good agreement between the measured and computed response characteristics under certain excitations, but considerable deviation was observed under other excitation. The three degree-of-freedom seated human body model, proposed in the literature, is further tuned to satisfy the measured apparent mass (APMS) and seat transmissibility characteristics in order to account for the body coupling with the deformable cushion. The validity of the proposed model is demonstrated by comparing its response characteristics with the measured data.

Acknowledgements

A personal desire to learn more about the teaching of ethics to nursing students eventually developed into a thesis. I have learned a great deal through the process but feel that it is only a small beginning. The generous support I received made the thesis imaginable and possible.

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CHAPTER 1

INTRODUCTION

This study examines (a) the competency of "moral knowledge and professional ethics" as outlined in the new curriculum for the education of nurses by the Ministère de l'Éducation du Québec; (b) the influence of Kohlberg's "ethic of justice" and Gilligan's "ethic of care" in the development of ethical decision making in nursing practice; and (c) learning strategies that are more effective in preparing nurses for ethical decision making in clinical practice. Briefly, then this study is a critique of the research, which focuses on ethical decision making in nursing and is grounded in the theories of Kohlberg, Gilligan, Noddings, and Benner who have focused on the evolving process of ethical decision making in general.

My interest in this topic has been generated by my work. I have taught various classes within the nursing program at Vanier College over the past twenty-six years but never ethics. I have had discussions with students in the clinical setting regarding ethical issues; however I have never felt adequately prepared or had the personal responsibility to teach the topic in the classroom. Nursing ethics has been taught in our program for the past 15 years. With the introduction of a new curriculum the total amount of hours devoted to the teaching of ethics in third year nursing will increase and the responsibility will be partially mine. The third year teachers are concerned that we approach this endeavour with increased self-knowledge and produce the best possible learning experience for the students.

When researching the topic, it became obvious that there are many different types of ethical theories. I explore the two theories that are mainly discussed in

nursing literature; the ethics of care and the ethics of justice. Carol Gilligan, a psychologist, author of *In a Different Voice* (1982) and Nell Noddings, a philosopher in education, author of *Caring: A Feminine Approach to Ethics and Moral Education* (1984) are the two theorists that form the foundation for the theories of ethics of care. The ethics of justice derive from traditional Western philosophy and educational psychologist Lawrence Kohlberg's Theory of Moral Development (1969,1976) later modified by James Rest (1979), also an educational psychologist.

Vanier College is one of three English language CÉGEPs (Collège d'enseignement général et professionnel) in Montréal, Québec. The nursing program is a three-year diploma program integrated into a post-two-year degree program with McGill University in Montréal. The students' ages range from seventeen to late thirties. They are Canadian and non-Canadian born. Vanier Nursing Program has a diverse population, non-Canadian born students may come from Russia, Ukraine, Poland, Haiti, Barbados, Jamaica, Mexico, Venezuela, Philippines, India, Pakistan, Iran, Ghana, Rwanda, The Seychelles, Mauritius, Israel, China, Vietnam, and Thailand to name a few countries. Canadian born students may be second generation Canadians from any of the above-mentioned countries or of anglophone or francophone backgrounds, or second generation Italian or Greek Canadians. The majority of students are female. Non-Canadian born students may have had their high school education in Canada, some may have had a qualifying year at Vanier College before they entered the nursing program. It would be difficult to gather meaningful data using Kohlberg's moral reasoning theory and Rest's Defining Issues Test (DIT) because of the levels and diverse types of education students receive before entering

Vanier College. Rest (1992) argues that the DIT is so heavily dependent on reading skills that its use is problematic when used with subjects whose first language is not English.

In the spring of 2000, the Ministère de l'Éducation du Québec (MEQ) sent schools of nursing in Québec guidelines of competencies for a new curriculum. The third year nursing faculty at Vanier College will develop learning activities to align with the new competencies for the third year program. A major competency in the fifth semester of a six-semester program, under the broad scope of socialization to the profession of nursing is "To use the ethics and values of the profession to understand one's own role." Forty-five hours have been allotted to this competency which is an increase of nine hours over the previous curriculum. This competency is aimed at: "Enabling a person to become competent in the practice of the profession i.e. enabling him or her to carry out the roles, tasks and activities of the profession at the level required for entry into the workforce." The program also includes educational goals, one of which is to: "Adopt an individualised clinical approach that respects the person's rights, beliefs, values and abilities" (MEQ, 2001, p. 8).

Why are nurses taught ethical decision-making?

Why is ethical decision making being taught to nursing students? In the past, nurses were seen as doctors' handmaidens. Times have changed. Today, nurses are recognized as having a distinct role in the health care system establishing unique relationships with their patients. The nurse has the role of a patient advocate with her

primary responsibility being the optimum well being of the patient, helping the patient in circumstances when the patient is vulnerable and in need of assistance.

> Nurses are now increasingly recognized for what they have become: specially-trained and certified advanced practitioners, with independent duties and responsibilities to their patients. The hierarchical model has increasingly given way to a collaborative model of the doctor-nurse relationship. Within this model, doctors and nurses work closely together, not only on technical questions of optimal care, but also in clinical ethics (Roy, Williams, & Dickens, 1994, p. 108).

Nurses, as professionals, must be able to make the best possible choices in their given circumstances. They must also be able to clarify and justify their decisions to patients, colleagues and society as a whole. They have a legal responsibility to do so. Nurse education programs have an equal responsibility to adequately prepare their students to be able to practice in an ethically and legally competent manner. Nurses must be prepared to make decisions but they must also have an understanding of the basic beliefs and values of our society and the knowledge base that influences these decisions.

Carl Rogers has defined the helping relationship as one "in which at least one of the parties has the intent of promoting the growth, maturity, improved functioning and improved coping with life of the other" (Sundeen, Stuart, Rankin & Cohen, 1998, p. 147). The authors also quote Imogene King as having "noted the importance of interpersonal relationships to the practice of nursing. She [King] views nurse-client relationships as 'learning experiences whereby two people interact to face an immediate health problem, to share, if possible, in resolving it and to discover ways to adapt to the situation" (p. 148).

The nature of ethics in nursing

To understand the terminology of ethics certain terms must be defined. Keatings & Smith (2000) define **ethics** as the philosophical study of morality, which is the systematic exploration of questions about what is morally right and morally wrong. And nursing ethics is the focus of moral questions within the sphere of nursing practice and the nurse-patient/client relationship. Bandman and Bandman (2002) state that nursing ethics is the critical-philosophical evaluation and justification of moral decisions in nursing.

The Ordre des infirmières et infirmiers du Québec defines Moral Knowledge and Professional Ethics as:

> Moral knowledge refers to the nurse's ability to justify a clinical decision made for the client's good when negative consequences are anticipated (Patenaude, 1997). This ability is based on an analytical, empathetic world view (Lambert, 1992) in which values are inseparable from health-care delivery and are constantly re-examined. [...] Professional ethics [...] deal with the duties and obligations that structure the nurse's conduct toward the profession, the public and the client, and govern such issues as respect for human dignity (OIIQ, 2001, p.15).

The Ordre des infirmières et infirmiers du Québec publishes a document, *The Outlook on the Practice of Nursing* that it distributes to all its members. It describes and delineates the values, standards, and practice of nursing in Québec and is used by nurses, teachers, administrators and researchers as a guideline to practice. It is a comprehensive document that is reflective of our times in the world and serves as an evaluation standard to ensure quality of service to the public.

> In 1996, the Bureau of the Ordre des infirmières et infirmiers du Québec (OIIQ) formally adopted a document entitled *The Outlook on the Practice of Nursing.* This outlook was defined based on client's and significant others' expectations and with the help of nurses from various areas of activity, geographical regions of Québec, health-care settings and field of practice....This "outlook" begins by outlining the beliefs and assumptions on which the practice of nursing is based. The beliefs and assumptions colour one's perception of the person (family, group or community), health, the environment and nursing care, which in turn orients professional practice....the descriptive statements relating to professional practice define the partnership with the client, the main functions of nurses (health promotion, disease prevention, the therapeutic process, functional rehabilitation), quality of life and professional commitment. These descriptive statements define the nature of nursing practice. They allow nurses to fully perform their roles and help them clarify this role to their clients, colleagues in other disciplines, the general public and the various levels of government (OIIQ, 1996, p. 6).

The ethic competency in the new nursing curriculum closely reflects the standards and values delineated in *The Outlook on the Practice of Nursing.* The Ministère de l'Éducation du Québec (MEQ) published the new curriculum called *Health Nursing Program of Study 180.A0* (2002) which contains 22 competencies. These are the competencies students are obliged to master before they graduate from a nursing program. The one competency concerned with "moral knowledge and professional ethics" states the student must learn "to use ethics and values of the profession to understand one's role". The following are the five subsidiary elements to the competency 1) to comply with professional values 2) to assume responsibility for actions and decisions 3) to understand the moral dimensions of the role 4) to consider various professional situations from an ethical point of view 5) to become involved in maintaining and improving the quality of nursing care. Comparing the competency to the current literature reveals the importance of reflective thinking and

narrative practices to the learning of ethics in nursing. "To assume responsibility for actions and decisions" is a professional obligation that at times has some inherent difficulties due to institutional constraints. "To understand the moral dimensions of the role" incorporates nurses' role in health promotion. "To consider various professional situations from an ethical point of view" makes reference to the ethical decision making process that nurses use when faced with ethical dilemmas. "To become involved in maintaining and improving the quality of nursing care" refers to the willingness and openness to work with fellow practitioners for the betterment of the profession, social responsibility, and life-long learning. This thesis examines how this competency and its components are reflective of the nursing literature on the teaching and learning of ethics in nursing.

Chapter Two of this thesis consists of a literature review on the nature of ethics in nursing including a critique of the theories of Kohlberg, Gilligan, and Noddings. Chapter Three addresses the theoretical perspectives and models developed to explain ethics of justice and ethics of care. Chapter Four includes an examination and critique of the guidelines of competencies on ethics in *Health: Nursing: Program of Study 180.A0*, the new curriculum sent to schools of nursing in Québec spring of 2000. Chapter Five offers the conclusions and suggestions for further research.

CHAPTER 2

THE MORAL DEVELOPMENT DEBATE

Kohlberg: Moral Development and the Ethics of Justice

In 1981 Kohlberg compiled his previous papers into a work, *The Philosophy of Moral Development*. He addresses the question posed by Socrates: "What is a virtuous man, and what is a virtuous school and society which educates virtuous men?" (p. xiii). Kohlberg argues that moral education does not entail teaching children to follow rules just because "rules are rules". In a democratic society children are taught why rules should be obeyed. Kohlberg asserts that most teachers are aware that they are teaching values by their behaviour alone and wonder if this is unjustified indoctrination. He does not think that moral education is the same as socialization. He speaks against the tendency of accepting "relativity of values" in moral education, which is a belief that everyone has a right to his own ideas. Defining moral values according to Kohlberg is not the same as having a set of positive personality traits. Kohlberg finds this approach called "character education" was prevalent in the 1920s and 1930s in the United States of America (USA). The problem arises because everyone has a different set of values. Kohlberg does not accept the process of values clarification as a solution to the problem of who is right. He says it identifies the differences between one's own values and the values of others but is not a sufficient solution to the relativity problem.

Kohlberg proposed a solution to the relativity problem in his 1958 Ph.D. dissertation, which was called "The Development of Modes of Moral Thinking and Choice in Years Ten to Sixteen." Kohlberg developed the following dilemma:

The Heinz Dilemma: In Europe, a woman was near death from a very bad disease, a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost him to make. He paid $200 for the radium and charged $2000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could get together only about $1000, which was half of what it cost. He told the druggist that his wife was dying and asked him to sell it cheaper or let him pay later. But the druggist said, "No, I discovered the drug and I'm going to make money from it." Heinz got desperate and broke into the man's store to steal the drug for his wife.

Then Kohlberg asks: Should the husband have done this? Was it right or wrong? Is your decision objectively right? If you think it is morally right to steal the drug, you must face the fact that it is legally wrong. Seventy-five percent said it was wrong to steal, though most said they might do it.

Kohlberg and his colleagues studied seventy-five American boys from early adolescence on. He then studied boys from different cultures to prove his theory was universal. Based on his results he developed and tested a theory of moral development that includes three levels, each with two stages that children go through as they mature and learn to deal with ethical concerns. (see Appendix A, p. 92) At level one children make ethical decisions based on a self-centered view of what is "right" to avoid punishment and later to meet their own needs as in "I'll do something for you if you do something for me". The third stage in level two is manifested by

living up to one's duties and responsibilities; stage four reflects doing one's duty in society and maintaining the welfare of the group. In the final level, stage five includes upholding the basic rights, values, and legal arrangements of society, and stage six is full moral maturity manifested through being able to utilize principles of justice and fairness in their reasoning. "Few people progress past level two. Women seem to plateau in Stage 3, and most men never move beyond Stage 4" (Burkhardt, M., Nathaniel, A., 1998, p. 98). Kohlberg states that his 6 stage theory of moral development corresponds to the moral philosophies of Kant, Hare, Frankena, Brandt, Rawls, and Raphael. "These criteria of morality include prescriptivity (a distinct concept of an internal duty), universalizability (a sense that judgements should be those all people can act on), and primacy (of moral over nonmoral considerations)" (Kohlberg, 1981, p. 191). Kohlberg was influenced by the work of philosopher John Rawls who developed a theory of justice. He wrote about a *veil of ignorance*, a method by which the people or institutions would give fair treatment to everyone regardless of social position.

> Thus people must choose principles of justice that they are willing to live with, whether rich or poor, black or white, male or female, or whatever. Rawls contends that, under these conditions, the first principle chosen would be the right to maximum individual liberty compatible with the liberty of others; the second principle would be that there is no justification of inequalities unless they are to the benefit of the least advantaged. Rawls claims that his principles of liberty and equality are not just the principles of Western liberalism, but would be those chosen by rational people, acting under the veil of ignorance, as they worked toward development of a contract that would maximize their individual values in any society (Kohlberg, 1981, p. 232)

Kohlberg (1984) discusses Gilligan's work started in 1976 that analyses the way persons make "real-life" moral-ethical decisions. Kohlberg found that these

dilemmas, such as a dilemma of whether or not to have an abortion focused on a conflict between care for the self and the care for the other. Kohlberg does not believe that what Gilligan calls an ethic of care is well adapted to resolve justice problems, problems which require principles to resolve conflicting claims among persons, all of whom in some sense should be cared about.

Kohlberg acknowledges Gilligan's argument that there is a possibility of gender bias in his theory and measures but denies he has ever stated that males have a more developed sense of justice than do females. He notes that young adult females might be less developed in justice stage sequence than males for the same reasons that working class males were less developed in justice stage sequence than middle class males. He also suggests that if women are not provided with the experience of participation in society's complex secondary institutions through education and complex work responsibility, then they are not likely to acquire those societal role-taking abilities necessary for the development of justice reasoning.

There is no doubt that Kohlberg's work has been widely accepted and used to structure and evaluate ethics education at all levels of education. What is astounding in 2003 is that it was accepted as a universal theory applicable to children of both genders. One must be careful not to reduce one's criticisms based on historical relativism. In the 1950s and 1960s when he began his work children were treated the same. Feminist seeking equality in education and work claimed there were no gender differences. They wanted fair and equal treatment. However, despite his claim that he never said that boys or male adolescents have a more developed sense of justice than do females, Kohlberg reveals a gender bias by choosing to include only boys in his

study. It is now, if not politically correct, at least politically acceptable to claim that girls think and behave differently from boys, it was not in 1960. That does not invalidate Kohlberg's work but it does make it appear incomplete. The female gender must be studied by educational psychologists for its own standard not rated against a male gender standard only to be found defective. And that is why Gilligan's work has been a turning point for all work related to moral development, education, and justice.

As Gilligan's work became known, the literature indicates that nurses were discontent with the teaching and learning of ethics and the use of Kohlberg's theory of moral development and Rest's Defining Issues Test (DIT). Rest, a student of Kohlberg, modified Kohlberg's moral judgement interviews and developed the DIT which uses standardised responses that the respondents rank. The use of the model and the test began to be questioned by nursing researchers. Another way of looking at nursing knowledge was evolving and would influence the teaching and learning of nursing ethics.

Munhall (1982) conducted a critical analysis of her own 1980 study on moral development. She initially had set out to determine the differences in levels of moral reasoning between nursing in different years and between nursing faculty using Kohlberg's theoretical framework. However, when Munhall began to study moral philosophy as part of her literature review she began to question the approach she had used to study a subject as complex as ethics. She found something incongruous about assigning scores to philosophical reasoning on complex ethical matters devoid of context and substance. Munhall identified four aspects in which she was critical of the scientific method and DIT approach to assessing levels of moral reasoning. (1)

Munhall criticised the use of hypothetical stories and scoring based on Kohlberg's theory of moral development, which was derived from a male perspective of the world, based on masculine values and beliefs. Citing Gilligan, Munhall argues the moral imperative that repeatedly emerges for women is an injunction to care, a responsibility to identify and alleviate the "real and recognizable trouble" of the world. It was demonstrated that women felt uncomfortable committing themselves in hypothetical dilemmas without context. (2) Munhall argued the DIT provides the subject with the ethical question and lists the ethical issues. This precludes establishing whether a student can identify the ethical issues and independently offer alternatives. (3) Munhall cites Rest, as suggesting the DIT should be used for evaluating ethics courses. This Munhall did but she began to question her rationale when her interest was to understand nursing students' moral reasoning ability not the efficacy of the ethics course. Goodpaster argues that the scientific method of measurement is naïve in that most people think in pluralistic frameworks, whereas stage theorists are monistic, emphasizing one ethical framework, i.e., egoism, legalism, utilitarianism, and contractarianism (cited in Munhall).

Finally, (4) Munhall advocates nurses examine all theories of psychology, not only moral development, and learn to recognize how we have accepted world views as developed and evolved from the male perspective. She argues that a grounded theory approach to her study would have been more appropriate and that this method as well as other qualitative methods of research has much to offer nursing in the beginning stages of theory development to avoid methodological fallacies. Critical of nurse researchers use of the scientific method she also contends nursing needs its own

grounded theory. "Until we dwell longer in our own house, we will always be externally referenced" (p. 48). In my own literature search for this study I found this to be the most frequently cited quote. It became a salient thought for nursing researchers and seems to have spurred a paradigm shift.

Nokes (1989) describing Kohlberg's theory writes that age and educational preparation were thought to facilitate moral development; individuals with more formal education preparation had often attained higher levels of moral reasoning. Kohlberg posited that his theory could be universally applied irrespective of the person's dominant culture or gender. Nokes criticism is that Kohlberg's theory was about moral thought not moral behaviour. Although he claimed that thought would dictate behaviour, his theory focused primarily on cognitive processes. He believed that persons at higher levels of moral development would not only think more comprehensively about a moral issue but also behave more morally. Nokes (1989) found that nursing educators had embraced Kohlberg's theory and had repeatedly applied it in a variety of clinical and educational settings. She notes that when Kohlberg's moral development theory was tested the results often were disappointing. Bindler found that nursing students were at low levels of moral reasoning. This result was not expected (cited in Nokes, 1989).

Munhall also expected to find differences in moral reasoning as measured by the DIT between the classes of baccalaureate nursing students and that of nursing faculty (cited in Nokes, 1989). Analysis found a statistical difference between the students and nursing faculty but both groups scored within conventional levels and were at a relatively low level of moral reasoning. Nokes reports that Rest provided

tables with expected means of different groups based on their educational preparation. Ketefian reports that a study of registered nurses showed that subjects used principled, or the highest level of moral reasoning in decision making less than 30 percent of the time, and at a level expected from junior high school students (cited in Nokes, 1989). Nokes sampled a group of staff nurses and found a moral reasoning score still lower than that found in the Ketefian sample.

Nokes found that a common reaction to low moral reasoning scores was to develop nursing educational programs designed to improve ethical reasoning levels. Seminars varying in length from a few seminars to entire semesters encouraged students to discuss ethical dilemmas. She observes that although courses were increased in length, at the conclusion, the faculty often reported that students were more sensitive to ethical issues; but statistical evidence of differences in moral reasoning before and after the course was not presented. Nokes remarks that despite the lack of evidence that change was occurring, writers on nursing continued to advocate helping nurses to "improve" their moral reasoning by participating in these dilemma discussions.

Crisham (1981) found that the length of time that people worked in nursing was related to the importance given to practical, as opposed to ethical, considerations when they were faced by ethical dilemma situations. Nokes found that years in nursing were related negatively to moral reasoning. Nurses who had worked for longer periods in nursing had lower moral reasoning scores on the DIT.
Nokes suggests that moral reasoning theory may need to be replaced by a more comprehensive theory of morality. The consistently low levels of moral reasoning of

nurses and nursing students are not congruent with the nature or the goals of the nursing profession. Belenky, Clinchy, Goldberger and Tarule (1986) wrote that Western culture often values, studies, and articulates attributes traditionally associated with the masculine while ignoring those associated with the feminine. Thus we have learned a great deal about the development of autonomy and independence, abstract critical thought, and morality of rights and justice in both men and women but less about the development of interdependence, intimacy, nurturance, and contextual thought. Developmental theory has established men's experience and competence as a baseline, against which human development is judged, often to the misreading of women.

Thus Nokes argues for the application of a different paradigm suggesting that morality is influenced by the environment in which the problem is being analysed. Moral is not an absolute but the "best fit" solution in a conflict between the needs of the patient, institution, other health care providers and the professional nurse. When seen through this perspective, the finding that more experienced nurses have lower moral reasoning than recent graduates can be explained. She contends that as long as caring and responsibility are perceived as female qualities, society will devalue them. What is required is a theory of caring that assimilates Kohlberg and Gilligan's positions. This theory of caring would not reflect a superiority of one gender over the another but rather a synthesis of the good from both models.

Duckett, Rowan-Boyer, Ryden, Crisham, Savik and Rest (1992) challenged the 1989 work of Nokes and the 1980 work of Munhall. Nokes and Munhall found that Kolhberg's 1969 theory of moral development and Rest's 1971 Defining Issues

Test (DIT) "indicated that nurses and nursing students had consistently lower than expected levels of moral reasoning" (p. 172). The authors argue that Nokes has erroneously compared *raw* principled reasoning scores (P) of nurses or nursing students with the P *percent* norms in the DIT Manual (Rest, 1988) and Guide for Defining Issues Test (Rest, 1987) which according to the co-authors led Nokes to make the "inaccurate conclusion" quoted above. The authors refute the claim that nurses and nursing students have "consistently lower than expected levels of moral reasoning". This article defends the research work done by Rest. Three authors, Duckett, Rowan and Ryden are also co-editors of the University of Minnesota School of Nursing ethics curriculum in nursing using a multi-course sequential learning program which used Rest's work as its conceptual base.

Nokes (1993) responded by stating that literature suggests that the DIT does not give consistent data when used with foreign-born nurses. American-born nurses scored significantly higher on the DIT and on the test of reading comprehension than did the foreign-born nurses. Diploma-prepared nurses scored significantly lower on the DIT and the test of reading comprehension than the graduates of the other two types of programs. Rest cited in Duckett, et al (1992) warned that since the DIT is so heavily dependent on reading skills its use is problematic with minority groups or subjects whose first language is not English. Nokes claimed that 23% of RNs [Registered Nurses] in New York State in 1989 were non-white. Nokes went on to quote Duckett et al stating that the "advantages of using the DIT include ease and speed of administration and scoring, minimal dependency on verbal expressiveness, and its standardization" (p. 382). Nokes reiterates the difficulty and questions the use

of the DIT if there are problems in interpreting the variety of scores, problems with use in samples of minority populations and its dependence on reading skills.

In a review of nursing ethics research Ketefian concluded that no clear trends have surfaced to guide nursing practice or education (cited in Parker, 1990). Parker finds that studies of moral reasoning of nurses derived from Kohlberg's moral development theory has yielded inconsistent results. Parker states that:

> the work of Kohlberg on the theory of moral development was readily adopted by nurse researchers and educators probably because of its conceptual clarity, logical staging process and inherent optimism. Nurse educators, in particular, found the theory appealing because it suggests selected educational strategies will promote moral development in students and practising nurses (Parker, 1990, p. 213).

Nokes also supports this view.

Parker compares three moral judgement instruments and analyses their underlying theoretical assumptions. Kohlberg developed the Moral Judgement Interview (MJI) which was later developed by Rest into the Defining Issues Test (DIT). Crisham developed the Nursing Dilemmas Test (NDT). Parker found that that the DIT remained the preferred measure of moral reasoning of nurses.

Parker also reports that the research demonstrates inconsistencies in the moral reasoning of nurses because subjects do not respond the same way in hypothetical situations as they would in real-life dilemmas. She contends that the disparity between reasoning in hypothetical situations and real situations may represent measurement error, which argues against the validity of current measures of moral reasoning. Parker argues that when subjects are asked to report real-life dilemmas, moral knowledge is acquired and constructed through a person's own experience and would offer a more direct reflection of individuals' true experience in resolving moral

conflicts. Furthermore, she asks how significant these moral reasoning measurements are to nursing when the tests do not enable an investigator to determine the ability of nurses to identify real moral dilemmas and their inherent ethical issues.

Parker (1990) challenges Kohlberg's unidimensional concept of morality and supports the existence of two moral orientations or modes of reasoning about morality: an ethic of justice and an ethic of care. An ethic of justice focuses on resolving conflicting rights and obligations in a fair and just manner. Responsibility, care and co-operation in resolving moral dilemmas characterize an ethic of care. Both an ethic of care and an ethic of justice, Gilligan (1982) claims, are essential components of moral reasoning. Although Kohlberg's theory and instrumentation may be valid for the variable of justice, it seems to lack validity for the care component of moral reasoning. Parker suggests although these moral orientations are not gender specific they are gender related. Although both genders use both orientations, males use the ethics of justice more often and females use the ethics of care more often. She goes on to say that nursing is a predominately female profession; the current justice conception of morality does not adequately measure the care component of moral reasoning. She also asserts that researchers Davis, Huggins and Scalzi, Miller, Munhall and Taylor have suggested Gilligan's theory and research methods intuitively fit the realities of nursing better than does Kohlberg's model. Parker does a comparative analysis to provide evidence for this assertion. Miller argues that in Kohlberg's theory men develop moral maturity through independence, while women according to Gilligan develop moral maturity through interconnectedness (cited in Parker). Parker further asserts that an ethic of justice

emphasizes separation, noninterference, and impartiality, while an ethic of care is characterized by attachment, relationality and interdependence. An ethic of justice claims to be context independent with a focus on individual freedom and rights to impartial treatment. An ethic of care acknowledges its context dependence and focus on responsibilities to individuals and avoidance of hurt. Gilligan and Wiggins argue that an ethic of care regards detachment (from self and others) as morally problematic because it fosters insensitivity and indifference (cited in Parker, 1990). Benner and Wrubel (1989) wrote that in the phenomenological view, emotions have a qualitative content. Emotions allow the person to be engaged or involved in the situation. Benner and Wrubel contend that rigid, consistent dampening of emotions may block attention and thoughts.

Parker concludes that an ethic of care is congruent with the nature of the nurse-patient relationship and the goals of nursing but that the nursing profession should probably subscribe to both an ethic of care as well as an ethic of justice.

Implications of Kohlberg's Work

Educators to this day continue to use Kohlberg's theory of moral development and the DIT to evaluate the effectiveness of moral and ethical educational courses and programs. The next two examples are schools that have used the DIT to evaluate the outcome of their ethics curriculum with puzzling and disappointing results.

The University of Minnesota School of Nursing has developed an ethics curriculum in nursing using a multi-course sequential learning program. The work of Rest forms the conceptual base for this ethics program. This ethics curriculum is a

product of the project "Ethics Education for Baccalaureate Nursing Students" written by Duckett, Waithe, Rowan, Schmitz and Ryden (1993) and supported by a three-year grant from The Fund for the Improvement of Post Secondary Education (FIPSE), U.S. Department of Education from 1987 to 1990. The project report *Lessons Learned from FIPSE Projects III* (1996) describes the ethics course as a single course, consisting of a number of modules that can be integrated into several classroom and clinical courses, throughout the undergraduate curriculum. The embedding of modules and activities is structured to constitute a single integrated course exposing students to ethical issues at all stages of their program in both classroom and clinical settings. The belief is that students are able to address ethical considerations with increasing sophistication as they mature in their educational experience.

Student learning was evaluated in multiple ways, including take-home exams, multiple-choice questions in course exams, a term paper, a written small group exercise, and a graded group presentation. For the project report students completed the DIT both before they began the program and after its completion. All student groups showed significant improvements in their scores on the DIT. However, the patterns of difference in performance on the DIT among the three treatment groups and between those groups and the control group show no consistencies that suggest that the gains are attributable to the revised strategy of the ethics instruction. The authors of the report conclude it is impossible to know the degree to which those gains are attributable to the ethics course, as opposed to the curriculum in general or to greater maturity of the students. The authors think it is reasonable to conclude, however, on the basis of other research, that an environment in which ethical and

moral issues are continuously raised fosters moral development. The authors of this report do not consider the possibility that there could be a deficiency in the DIT. Students in this program continued to view ethical modules as add-ons to their courses despite the fact that other course content had been reduced to accommodate the ethical issues. This persistent view may have arisen from a faculty attitude that the ethics units belonged to the ethics faculty rather than the whole faculty. Some students expressed a preference for a complete course devoted to ethical issues rather than separate units throughout the program. Project directors had to work hard to retain those parts of the courses which had originally been agreed would be devoted to ethical issues. The authors of the project report concluded this problem was partly due to instructor turnover and the need to work with teachers who had not been party to the original agreements.

A study done by Heitman, Salis, and Bulger (2001) at University of Texas School of Public Health to explore whether their course "The Ethical Dimensions of the Biomedical Sciences" has an effect on students' principled moral reasoning, as measured by the DIT produced interesting results. The authors of this study report that the DIT developed by Rest at the University of Minnesota Center for the Study of Ethical Development is the instrument used most frequently to measure moral reasoning skills and the effects of education on moral reasoning. Scores measure the extent of "principled" reasoning behind the individual's assessment of the cases. The authors of this study report that DIT scores increase consistently with subject's age and education level unlike the results found by other researchers discussed in the next chapter. The data for this study was analysed at the University of Minnesota Center

for the Study of Ethical Development. The primary analysis assessed the course's effect on principled judgement. It revealed that the students showed no significant after-course improvement in principled judgement as measured by the DIT. Indeed, the pattern in six of the eight sub-groups was for after-course scores to drop slightly. Follow up analysis of the influence of students' gender and location of undergraduate schooling indicated neither gender nor location of education had a significant effect except for one group. Men educated in the U.S. after-course scores declined somewhat, while those of both groups of women and men not educated in the U.S. either improved very slightly or stayed essentially the same. The authors find the outcome surprising and frustrating. Upon reflection, the authors concluded that principled reasoning is only one of a number of skills and concepts that they hope to teach and foster in their course. Heitman, Salis and Bulger (2001) cite Rest, Narvaez, Bebeau and Thoma who note that Kohlberg's theories, and thus the DIT, address formal ethical structures of society, which they call macromorality, do not illuminate the micromoral phenomena of personal, face-to-face interactions in everyday life. Thus the authors suggest that it is essential to ask different questions or use different methods to evaluate the complex issue of the outcomes of the course. The authors go on to report that recent observations by Bebeau suggest unchanged DIT scores may mask important differences in moral sensitivity and reasoning. The authors seem to deflect criticism for the possible deficiencies in the DIT to the possibility of differences in moral sensitivity and reasoning skills of the subjects.

Carol Gilligan: Moral Development and Ethics of Caring

Gilligan (1982) argues that women when confronted with an ethical issue use a more egalitarian, empathetic approach to moral reasoning than men who she argues are concerned with issues of fairness and justice. Gilligan, a student of Kohlberg's challenges the theory of moral development, claiming that it ignores women's pattern of decision making about moral problems. Her approach to moral reasoning takes into consideration partiality, context, and relationships. She outlines major theories of psychological development in the Western world that have found women either deficient or underdeveloped. She notes that Freud in the 1920s found women to envy that which they missed and quotes Freud as concluding that women "show less sense of justice than men, that they are less ready to submit to the great exigencies of life, that they are more often influenced in their judgements by feelings of affection or hostility" (p.7). Chodorow said that because women are universally responsible for early childcare they come to be defined in relation and connection to other people more than men are (cited in Gilligan). She contends that girls having an early close relationship with their mother, experience themselves as like their mothers thus fusing the experience of attachment with the process of identity formation. Boys in defining themselves masculine separate themselves from their mothers and experience sexual issues with issues of separation.

Lever states that in play, girls are much more likely to have a pragmatic attitude, tolerant in their attitude towards rules and more willing to make exceptions to rules. She claims that through games boys learn independence and organizational

skills whereas girls in their more intimate games learn cooperation, empathy and sensitivity toward the other (cited in Gilligan).

Gilligan goes on to describe Erikson's eight stages of moral development which uses male developmental tasks to describe the identity acquisition for males as well as females. For example in middle childhood years children are seen to either attain a sense of industry versus a sense of failure. Gilligan relates that Erikson views girls as having their identity acquisition delayed until they knew by which male they would be defined. Gilligan also introduces Horner's work which describes women's fear of success and threatened social rejection which affects them in such a way that they jeopardize their education or career development in order to avoid competitive achievement.

Gilligan goes on to criticize Kohlberg's six stage theory of moral development of childhood and despite the universality claims of the theory, women rarely reach the higher stages of development. She notes that Kohlberg and Kramer consider that if women enter the male competitive job market they too would reach higher levels of moral development. Kohlberg cited in Gilligan claims that women generally reach the third stage, which is equated with helping and pleasing others but inadequate overall. Gilligan's response is that the traditional traits that have defined the goodness of women, their care and sensitivity leave them deficient in their moral development. Gilligan contends that only when theorists begin to recognize the importance of attachment in women's development will they view the full range of human development for both genders.

Gilligan describes the perspectives of an eleven-year old, Amy and a college student, Claire responses to the Heinz dilemma. They both see the dilemma as a failure of response as opposed to a conflict of rights. Claire exhibits an ethic of responsibility in the broader societal sense but according to Kohlberg's scale this causes her moral judgments to regress. Claire because of her own stage of moral development views the Heinz dilemma from the experience of relationship, the capacity to understand what someone else is experiencing. Gilligan argues that she sees the druggist preoccupation with profit as a failure to understand. She argues that Claire's view is that of an ideal of care, an activity of relationship, of seeing and responding to need, not leaving anyone alone.

Gilligan's reinterpretation of women's experience is that despite differences in power experienced as children in the parent-child relationship they learn that through the ethics of justice and care, they will be treated fairly, experience responsiveness and inclusiveness, that no one will be left alone or hurt. She reports that when four female college students are asked to describe the meaning of morality they independently respond in terms of meeting one's responsibilities and obligation to others, goodness in service, not hurting others.

Gilligan (1982) reports that Haan's study on college students and Holstein's three-year study of adolescents and their parents indicate that the moral judgements of women differ from those of men. Women's judgements are tied to feelings of empathy and compassion and are concerned with the resolution of real as opposed to hypothetical dilemmas. But as long as results of development studies based on the responses of male subjects are used as the standard of measure, the thinking of

women will often be classified with that of children. With birth control and abortion women have been given public choice but privately they still grapple with feelings of obligation and duty that is interconnected with conventions of femininity and adulthood. Gilligan studied how women deal with choices by conducting an abortion study designed to clarify the ways in which women construct and resolve abortion decisions.

> The abortion study suggests that women impose a distinctive construction on moral problems, seeing moral dilemmas in terms of conflicting responsibilities. ...The abortion study demonstrates the centrality of the concepts of responsibility and care in women's constructions of the moral domain, the close tie in women's thinking between conceptions of the self and morality, and ultimately the need for an expanded developmental theory that includes, rather than rules out from consideration, the differences in the feminine voice. (Gilligan, 1982, p. 105).

Gilligan (1982) notes that while an ethic of justice proceeds from the premise of equality – that everyone should be treated the same – an ethic of care rests on the premise of nonviolence—that no one should be hurt. She argues that for a life-cycle understanding to address the development in adulthood of relationships characterized by cooperation, generosity, and care, that understanding must include the lives of women as well as of men. Gilligan (1998) suggests a progression of moral thinking through three phases, each which reflects greater depth in understanding the relationship of self and others, and two transitions that involve critical reevaluation of the conflict between responsibility and selfishness (cited in Burkhardt and Nathaniel) (see Appendix B, p. 94).

Noddings: Moral Development and Ethics of Caring

Noddings (1984) writes that moral development and education are rooted in the parent-child relationship and the memory of it. She examines what it means to care and to be cared for and how caring functions in an educational context. The use of the "feminine" refers to feminine characteristics of receptivity and responsiveness rather than the female gender's approach to ethics. She writes how the caring person needs response from the one being cared for in order for the relationship to grow. Many nurse theorists advocating a paradigm shift in nursing education refer to Noddings' work.

Noddings contends that there are two feelings universal in humankind. The first is the sentiment of natural caring such as a mother has for her child. The second sentiment is our memory of our own best moments of caring and being cared for which compels us to respond to the need of the other. Noddings compares the transfer of feeling to the transfer of learning in the intellectual domain. For her ethical caring requires effort that is not needed in natural caring, but this does not mean natural caring is superior to ethical caring but rather that ethical caring is dependent upon natural caring. This impulse to act on behalf of another is a choice that is made because of a strong desire to be moral derived from a fundamental desire to remain related. Noddings says that an ethical ideal is preferable to a principle as a guide to moral action. She argues that principles in philosophy are considered universal but seem to depend on a concept of sameness. She says that in order to accept and apply principles we must ignore the qualities that give human predicaments their uniqueness and in doing so we often lose the very qualities that give rise to the moral question in

the situation. In effect principles can give guidance in moral thinking but no real guidance for moral conduct in concrete situations. Noddings discusses Kohlberg's model of moral reasoning and that women's development seems to stop at Stage 3 which relates to meeting one's duties and responsibilities. She suggests that women are at this stage because they do not fit the justification/judgement paradigm. She goes on to discuss that women prefer to discuss moral problems in terms of concrete situations, they approach moral problems not as intellectual problems to be solved by abstract reasoning but as concrete human problems to be solved in living. Noddings claims their approach is founded in caring.

Noddings includes a discussion of how moral education is a community responsibility not exclusively the responsibility of the home, church or school. Her contention is that intelligence, morality, and emotional well being cannot be separated. She claims that the human being is an integral composite of qualities in several domains that should be nurtured together. Her view is that every educational institution's primary aim should be the maintenance and enhancement of caring. Noddings asks if "happiness" is the primary aim of life. She contends that a trouble free life is for one unimaginable but it is better to be with someone in time of trouble than to be permanently alone. The aim of life then is not to avoid pain and be trouble free but she says that the primary aim of life is caring and being cared for, to be fully engaged and receptive to life.

For Noddings the caring teacher is one who receives the student, for the interval of caring, completely and nonselectively. When a teacher asks a question of a student she not only receives a response from the student, she also seeks involvement

from the student; the student is infinitely more important than the subject matter. The teacher is also a model for moral behaviour.

> A teacher cannot "talk" this ethic she must live it, and that implies establishing a relation with the student. Besides talking to him and showing him how one cares, she engages in cooperative practice with him.... Everything we do, then, as teachers, has moral overtones. Through dialogue, modeling, the provision of practice, and the attribution of best motive, the one-caring as teacher nurtures the ethical ideal (Noddings, 1984, p. 179).

Nothing is more important to Noddings than nurturing the ethical ideal in the student and she emphasizes that training for receptivity involves sharing and reflecting aloud. She argues that dialogue and practice are essential in nurturing the ethical ideal. Bevis and Watson (1989) point out that Noddings contends that moral education for caring involves modeling, dialogue, practice and confirmation. The teacher's caring has the power to help the student move towards ethical maturity. Noddings' emphasis on dialogue and practice are mirrored in the current work of Benner, Tanner and Chesla (1996). They propose that students telling their own stories can increase their skills in reflecting on ethical comportment and engaged clinical reasoning.

Crowley (1989) believes that Noddings' ethics of care can better raise moral perception and sensitivity in student nurses. Noddings encourages educators to create a caring dialogue with students that will foster the students' ability to make moral choices under oppressive conditions, choices that enhance rather than diminish their vision of themselves as caring practitioners. Noddings believes it is in sharing, this exploration into what the student thinks as well as "why s/he thinks what s/he

thinks" that the student is given the opportunity to achieve a greater degree of self-understanding.

Crowley (1994) further discusses Noddings' approach to the process of ethics education. On the process of moral education Noddings (cited in Crowley, 1994) writes, "We cannot separate means and ends in education, because the desired result is part of the process, and the process carries with it the notion of persons undergoing it becoming somehow "better'" (p. 79). She reports that Noddings' model for moral education is based on the teacher-student relationship and is characterized by three processes that serve to enhance the ethical ideal—dialogue, practice, and confirmation. Noddings advocates that a dialogue between student and teacher can only occur in a relationship based on mutual trust, based on the knowledge that the student will always be regarded as more important than the subject matter. Crowley notes that "trust is also nurtured through cooperative learning with the student. The teacher does not merely impart knowledge but rather she engages in a cooperative effort with the student that involves '...sharing and reflecting aloud" (p. 79). Their relationship is built on a venture of mutual discovery. The teacher, by sharing how she thinks, becomes a model of caring practice. In referring to Noddings views on the process of confirmation, Crowley writes that the teacher "always approaches the other as though the other has a respectable motive, in a sense, we attribute the same noble motives to the acts of others that we attribute to our own acts" (p. 79). Thus "with this approach to moral education in nursing, the pursuit of the caring relationship--between student and teacher, and nurse and patient--is valued above all else" (p. 80).

I have long thought that there is a correlation between the therapeutic nurse-patient relationship and the nursing instructor-student relationship. Nursing students are taught to care. The literature on caring within nursing education is extensive. Grams, Kosowski, and Wilson (1997) state that it is well cited that a student nurse learns how to care if the student experiences caring in the student-teacher relationship. Wehrwein (1996) writes that nursing faculty must not only teach ethics to prospective nurses but also demonstrate it in relationships with students. Principles for ethical educational practice include respect, open communication, boundary setting, consistent behaviours, and personal values. Csokasy (2002) argues that faculties should incorporate a more humanist approach to evaluation along with the traditional-behaviourist method of examinations that meet the requirements of the profession's external accrediting bodies. The literature seems to indicate that nursing teachers must adopt a collaborative approach to the teaching of ethics.

Crowley (1994) also discusses how Noddings' ethics of care views the "ethical self" existing only in a relationship. Noddings argues that the choice to enter a relationship is based on our vision of our "ethical ideal". Our ethical ideal is rooted in the memory of being cared for by our mother and our memory of our own best caring moments as we cared for others. Crowley writes that Noddings stresses that caring is a relationship and cannot happen unilaterally. In a caring relationship the one being cared for must indicate in some way that the caring has been received. She goes on to describe that Noddings does not discount an ethics of rules and principles (justice). But does say that the process of applying the principles and rules often discounts the context of the situation and by so doing frequently is destructive to the

very relationship that the ethics of care means to preserve. Crowley further discusses feminist criticisms of Noddings' theory, in that the ethics of care inability to address the oppressive conditions in women's and men's lives. She relates the criticism of Card and Houston who argue that Noddings' ethics of care does not address the moral responsibility we have to the world's inhabitants with whom we share humanity. Noddings writes about our fear of the *proximate stranger* entering our circle obliging us to care for them but depleting our resources for our intimates. Crowley cites Card, as arguing it is this fear of strangers in Noddings' theory, which ignores our moral responsibility to help most of the world's inhabitants who do not have a history of helping one another. She also cites critics as being concerned that Noddings' ethics of care will not help women find ways to end exploitative relationships. Critics argue that Noddings' theory commands caring for the needs of others but may diminish the recognition of the needs of the self. They also argue that considering woman's historical position of caregiver in, Noddings' theory may perpetuate women being valued only to the extent to which they serve others. Noddings responds to those critics by saying that the person must also care for the self or in her terminology "remain one-caring" and move toward the "ethical ideal". To pursue the "ethical ideal" in the ethics of care a woman's responsibility is also to care for the self.

In this chapter I have given an overview of the evolution of nursing ethics over the last thirty years including salient works that are frequently referred to in the literature. Two approaches of nursing ethics evolved among nursing theorists the ethics of care versus the ethics of justice. The ethics of care originated with the work of Carol Gilligan and Nell Noddings and has its focus on relationships and

responsibility. The ethics of justice originates from the traditional approach of discussing ethical dilemmas in Western philosophy. Kohlberg developed a theory of moral reasoning, which has received criticism for being incomplete and detrimental to women and not reflective of the moral reasoning of nurses. Noddings' model of moral education includes the processes of dialogue, practice and confirmation.

CHAPTER 3

THEORETICAL PERSPECTIVES AND MODELS DEVELOPED TO EXPLAIN ETHICS OF JUSTICE AND ETHICS OF CARE

During the 1980s and 1990s there was discussion about the level of nursing students' moral development and moral reasoning ability. As a result of Gilligan (1982) and Noddings (1984) work, nurse theorists began to look at different ways of developing nursing theory. Theories were examined for their applicability to the nursing profession. The nursing profession was unique but nursing ethics remained derivative to the works of other theorists.

In this chapter I examine the work of nurse theorists that have influenced the development of teaching nursing ethics as it exists today. I begin with Fry (1989) who looks at theories of caring in a search for a theory that is congruent with the nature of nursing. Cooper (1991) reveals the importance of narrative by analysing nurses' moral decision making process and calls for an education curricula to include the ethics of care. Benner (1991) argues that nurses learn ethics of care through narrative and practice. Diekelmann (2001) reports on a unique nursing theory, developed from the narratives of nurses. Ironside (2001) encourages nursing teachers to enhance their pedagogic literacy and provides a comparison of theoretical contexts in nursing education. Jaeger (2001) discusses the importance of moral sensitivity for maintaining moral behaviour. And finally Benner, Tanner and Chesla (1996) discuss how nurses develop ethical expertise and recommend approaches for educators to structure experiential learning. Benner, Tanner and Chesla argue that intuitive ethical expertise is a mature or higher form of moral reasoning.

Models of Caring: Fry

Sara Fry (1989) examined whether there actually was a separate field of inquiry of nursing ethics or simply a subcategory of biomedical ethics. Fry noted that most efforts to describe nursing ethics from 1979 to 1989 adopted a view that depicted nursing ethics as a form of inquiry that was equal to medical ethics within the general field of biomedical ethics. Accordingly Fry found that biomedical ethics had been applied to the practice of nursing using frameworks from bioethical theory and liberal theory of justice. The result is that the studies in nursing ethics have used justice-based theories of moral reasoning from cognitive psychology to interpret their findings about nurses' moral behaviour, judgement, and reasoning. Fry found that the result was a trend in nursing ethics that did not take into consideration the role of nurses in health care, the social significance of nursing in contemporary society, or the value standards for nursing practice. Fry went on to say that although autonomy and producing good are related to the practice of nursing, neither of these values which are derived from theories of biomedical ethics had been convincingly demonstrated to be the primary moral foundation of nursing ethics.

Fry delineates caring as (1) a mode of being, caring is natural – a feeling or an internal sense made universal in the whole species. She considers (2) that a conceptual form of caring must exist as a structural feature of human growth and development prior to the point at which the process of caring actually commences. And (3) she states that caring is identified with moral and social ideals. Fry goes on to say that because the practice of nursing is socially mandated to assist with the health

needs of individuals, caring becomes strongly linked to the moral and social ideals of nursing as a profession.

Fry compared three models of caring that she considered relevant to a theory of nursing ethics. Fry compared Noddings' model of caring, Pellegrino's moral obligation model of caring and Frankena's moral-point-of-view model of caring. She describes Noddings' work as theoretically based on ethics and social psychology. Noddings views caring as a feminine value rooted in the notions of receptivity, relatedness, and responsiveness that is applicable to both genders. Fry describes Noddings' view of caring as the acceptance by the caregiver of the one cared for (receptivity), the relation of the caregiver to the one cared for as a fact of human existence (relatedness), and commitment from the caregiver to the one cared for (responsiveness). She describes Noddings' ethical caring as simply the relation in which we meet another morally. Noddings claims that we are not guided by ethical principles but by the strength of the ideal of caring in which we are a partner in human relationships. Fry argues that although Noddings would deny advocating a feminist model of caring, Noddings' ethics of care might not be attractive to nurses who are not female. However, Fry finds Noddings' model a viable theoretical framework that realistically represents the nature of the nurse-patient relationship.

Fry describes Pellegrino as a humanist and a physician who has written extensively on caring as a derivative value of the physician's obligation to do good. Pellegrino describes care as compassion or concern for another person, doing for others what they cannot do for themselves, taking charge of the medical problem experienced by the patient, and ensuring that all procedures are carried out with

conscientious attention to detail and with exemplary skill. Fry views Pellegrino's notion of care as a derivative value of patient good as it conforms to bioethical theorizing. She argues that nurses' caring goes beyond Pellegrino's notion of patient good because the nurses caring relates to the patient's status as a human being. For this reason, Fry does not think that Pellegrino's moral obligation model of caring is appropriate to the development of a theory of nursing ethic.

Fry describes Frankena's moral-point-of-view (MPV) model of ethical theory which she considers relevant to the development of nursing ethics. Frankena describes MPV theory as subscribing to a certain moral principle (or value) and adopting a general approach, perspective, stance, or vantage point from which to proceed. Fry posits that Frankena's value of caring takes the form of Kantian respect for persons or Christian love. It results in a moral point of view that includes direct caring about what goes on in the lives of others. It does not entail the use of any particular test of justifiability, validity, or truth. Fry contends that Frankena's view of caring is different from Pellegrino. She states Pellegrino's view of caring is an indirect focus of caring through patient good which provides the basis for physicians' evaluative judgements. Frankena's view of caring is direct and involves taking a moral point of view toward caring as a fundamental moral value or principle for normative judgements involving persons. Fry argues that although Frankena's and Noddings' view of caring are different Frankena's method of arriving at caring as a lived principle for a system of morality (taking a MPV) bears some relevance to Noddings' views and to nursing ethics.

Finally Fry, taking into consideration the models of caring proposed by Noddings, Pellegrino, and Frankena, proposes several recommendations for the future development of a theory of nursing ethics. (1) Nursing requires a moral point of view of persons that considers the nurse-patient relationship rather than theoretical interpretations of physician decision making. Present theories of medical ethics do not fit in with the practical realities of nurses' decision making in patient care. (2) The value of caring ought to be central to any theory of nursing ethics. Fry states that there appears to be an important link between the value of caring and nurses' views on persons and human dignity. (3) Developing a moral point of view theory does not need the use of any test of moral justification. The moral point of view of theory of nursing ethics should not be defined by reference to any external system of justification. (4) A moral point of view model of nursing ethics with caring as a central value will contribute to biomedical ethics.

The Role of Narratives in Ethical Practice

Cooper (1991) contends that research to date assumes that nursing uses a principle-oriented framework in moral activity. She argues that this is evident by the use of tools such as Kohlberg's Moral Judgements Interview, Rest's Defining Issues Test and Crisham's Nursing Dilemmas Test all which use a principle-oriented framework. Cooper describes a principle-oriented ethics as built on a model in which reliance upon rules and principles is primary in moral action and justification. She describes rules and principles as playing a secondary role in the ethic of care and that moral concern is with needs and corresponding responsibility as they arise within

a relationship. Interdependence is valued as the ideal moral position and moral response is individualised. Cooper's study analysed nurses stories but chose one to illustrate the moral decision making process. It was found that the nurse was committed to the use of the principles of patient rights and patient autonomy. But it was shown that the nurse's moral response within the nurse-patient relationship was guided by personal involvement, moral struggle, and emotional investment. Cooper's findings illustrate "a caring relationship, embodying mutuality and reciprocity" (p. 27). In her conclusions Cooper speaks of nursing narratives depicting the complexity and contextually dependent nature of nursing ethics. Nursing stories arouse intellectual curiosity and call for an intuitive and emotional response. "The narratives of expert nurses may constitute the best guides to theoretical constructions....The development of nursing ethics requires radical responses, ...a revision of educational curricula to include the philosophical consideration of care (p. 30).

Carper (1978) wrote that the body of knowledge that serves as the rationale for nursing practice has patterns, forms, and structure that exemplify characteristic ways of thinking about phenomena. She argued that understanding these patterns was essential for the teaching and learning of nursing. She wrote that the teaching of ethical theories and principles was required for dealing with the complexities of moral judgements and choices. Knowledge of ethical codes would not provide answers to the moral questions in nursing nor the necessity for having to make moral choices. She saw a need for new methods of inquiry and different conceptual structures to discover what it means to know and what patterns of knowing are valuable to nursing practice.

Benner (1991) argues that communities and narratives as a repository of practice and traditions provide the basis for everyday ethical comportment and formal ethical judgements. Procedural approaches to ethics that adjudicate rights and principles cannot stand alone because they cannot provide a positive statement of the nature of the good life, what is worth preserving, and yet they are dependent on an everyday practical knowledge of the good to sustain them. Benner emphasizes the development of skillful moral comportment that occurs in practice. She uses the term ethical comportment to refer to the embodied, skillful know-how of relating to others in ways that are respectful and support their concerns. Benner contends that comportment encompasses nuances such as stance, touch orientation—thoughts and feelings fused with physical presence and action. The stories of nurses become narrative themes that evoke memories and patterns of concerns. The narrative memory can evoke or enhance pattern recognition. The thematic categories tell about nurses' ethical concerns and ethical comportment of nurses. Nurses do not deliberately look for stories that would illustrate an ethical principle or category. If given a principle of justice they do not easily conjure up a story to illustrate the issue. Benner argues that procedural ethics based on rights and justice alone cannot answer all the questions about what constitutes care and how we ought to care, because a principle-based ethical discourse is not automatically translated into everyday ethical comportment or engaged ethical narratives.

> We cannot get beyond experience, and we must not rely on our theories to distance us from skillful moral comportment in concrete, specific, local situations...If we subject our theories to our unedited, concrete, moral experience and acknowledge skillful moral comportment calls us to be not beyond experience, but tempered and taught by it....Disengaged reason and rational calculation cannot

> replace engaged care as a moral source of wisdom. ... We need to reintroduce narrative both in our practice and in our discourse on ethical practice, so as to extend, alter, and preserve ethical distinctions and concerns. (Benner, 1991, p. 19)

Diekelmann (2001) directs a study that has been on going for 12 years in which over 200 students, teachers, and clinicians have been interviewed to date. Participants are asked to respond to the following: "Tell a story about a time that reminds you of what it means to be a student, teacher, or clinician in nursing education." The author claims Narrative Pedagogy arises out of the common lived experiences of the respondents. The study uses interpretive phenomenology to hermeneutically analyse interviews that are transcribed into text by research teams. Diekelmann describes the hermeneutical process as a circular, seamless, reflective approach to inquiry with an emphasis on depth and detail.

> Interpretive phenomenology, specifically, the work of Martin Heidegger, Hans-Georg Gadamer, and Maurice Merleau-Ponty were the background for this study. As the interpretation of interviews progresses, the researcher studies philosophic texts to challenge and extend their underlying interpretive thinking. These philosophic texts, because they explicate the human way of being, assist the interpreters in their thinking and in staying focused on identifying common experiences or practices. This study describes the common experiences (identified as themes and patterns) of students, teachers, and clinicians in nursing education. Throughout the study the researcher and team members also read widely and brought texts from varying perspectives (critical, feminist, and postmodern) to bear on emerging interpretations. (Diekelmann, 2001, p. 56)

Through the process of hermeneutical analysis common themes are identified. During the analysis, patterns emerge from the relationship of the themes and Diekelmann names these patterns "Concernful Practices" describing how respondents experience teaching and learning. The author describes the role of the interpretive

researcher as a listener who does not attempt to evaluate but seeks hidden interpretations. By analysing the underlying patterns, the "converging conversations" that emerge according to the author describe the self-reflective process that can reveal hidden understandings of learning stimulating new possibilities for nursing education.

This on-going process has revealed the following nine patterns or concernful practices of schooling, learning, and teaching in nursing:

- *Gathering:* bringing in and calling forth
- *Creating Places:* keeping open a future of possibilities
- *Assembling:* constructing and cultivating
- *Staying:* knowing and connecting
- *Caring:* engendering community
- *Interpreting:* unlearning and becoming
- *Presencing:* attending and being open
- *Preserving reading, writing, thinking, and dialogue*
- *Questioning*: meaning and making visible

> *Narrative Pedagogy is a new pedagogy for nursing with significant commitments to interpretive phenomenology; however, it also creates a space and place for conventional and alternative pedagogies to converge and for new pedagogies to emerge.* In this way, Narrative Pedagogy is an alternative approach that uses all pedagogies while it revisions nursing education and creates new possibilities for schooling, teaching, and learning. Narrative Pedagogy is a converging conversation that is not simply a melding of conventional, feminist, phenomenologic, critical, and postmodern perspectives. It is a commitment to unending conversations that call forth and embrace, while also moving beyond issues of power, critique, and deconstruction. (Diekelmann, 2001, p. 65)

This study is most interesting and provocative. I think it provides possibilities for exploration in the teaching of ethics in nursing. By first discovering the

predominant patterns or concernful practices in nursing education, then nurse educators can better discover how nursing students learn to deal with ethical issues and make ethical decisions. It supports the results of previous research that reveals nurses make decisions in context not based on principles or rules of decision making.

Pedagogical approaches in nursing

Ironside (2001) did a review of 15 years of nursing literature. A total of 124 articles and 42 books were analysed for pedagogic approaches to schooling, teaching, and learning. The comparison provides an interpretive review of the common commitments and possibilities of these pedagogies with the purpose of encouraging nursing teachers to reflect on approaches to schooling, and develop studies to evaluate the usefulness of these approaches. Included is a very helpful chart analysing the conventional, critical, feminist postmodern, and phenomenologic approaches to education for general themes, teacher/student relationship, strengths, and limitations. This work would be most helpful for enhancing new nursing teachers' pedagogic literacy as they have little or no educational training before starting to teach. Nursing teachers' graduate degrees are usually in nursing not education.

Nurse educators have long known of the difficulty that novice nurses have adapting their values and behaviours acquired in their education to the realities of the workplace (Kramer, 1974). To help ameliorate this problem, courses have included strategies to prevent burnout, "described as the health professional withdrawing emotionally, becoming apathetic, and losing interest, energy, and dedication to their work" (Edelman & Mandle, 1998, p. 355). By being made aware of the issues and

stresses before they graduate novice nurses do not feel totally responsible for the difficulties they confront. Effective preparation to cope with this problem can influence novice nurses to retain the values, moral sensitivity and behaviour of their education.

Jaeger (2001) explores the meaning of moral sensitivity. Jaeger uses the term 'moral sensitivity' in a broader sense than what is typically meant by 'moral perception'. Jaeger says that educators have the responsibility of educating nurses to recognize moral issues and develop moral reasoning skills but hospital administrators create the conditions of the workplace in which nurses must exercise this expertise. Jaeger goes on to explain that moral reasoning is used as the justification for performing particular acts, whereas moral sensitivity is a practical skill that enables one to recognize when an act, situation or certain aspects of a situation have moral implications. Jaeger argues that treatment protocols and budget restraints often restrict caregivers' ability to provide treatment to their patients. The challenge seems to be to find a balance between generic institutional policies and the needs of patients with individual differences, beliefs, and values. The task is made more difficult in our ethnically diverse populations where hospital policies fail to recognize cultural, racial, gender or other differences significant to an individual's experience of health and disease. Jaeger's concern is that the present social and political conditions, health care workers are in danger of losing their capacity for moral sensitivity. At a 1999 ethics symposium in Toronto, The University Health Network, management admitted that although the hospital as the largest hospital institution in Canada, in the largest city, in the largest province is now ranked as the most cost efficient also ranked at the

bottom in patient satisfaction. Vetlesen cited in Jaeger claims that emotions are integral to moral perception. Vetlesen argues that when health care workers experience 'emotional numbing' they are in danger of losing their capacity to be morally sensitive and ignorant of the human reality confronting them. Yarling and McElmurry (1986) argue that because of institutional constraints nurses are often not free to be moral. They find that often nurses are not able to support their patients in situations where hospital and medical interests are overriding patient's dignity, wishes and rights. One is not free to be moral if one is emotionally numb and has lost the ability to be morally sensitive. This concern is related to budgetary constraints as well as issues of power.

Benner, Tanner, and Chesla (1996) contend that in our Western perspective emotion has been separated from reason. It has been distrusted and separated from our thinking and knowing. The authors note that the experienced nurse knows when something is wrong often by an emotion, they say "I felt uneasy" or "I felt uncomfortable". Through their expertise they have learned normal patterns of patient behaviour, they have learned to know their patient and it is often their emotions that act as indicators that something is wrong.

Expert practitioners do not think of every little detail and step of a procedure to perform their work. Through their experiential learning they become experts in problem solving, they do what is called in educational psychology "chunk" or "bundle" information, which helps them to be efficient practitioners. Benner (1984) wrote that attempts may be made to make explicit all the elements that go into a nursing decision, but experts do not actually make decisions in a procedural way.

They do not build up conclusions, element by element; rather they grasp the whole. Polanyi said the expert always knows more than he or she can tell (cited in Benner 1984). Benner writes about a phenomenon in professional practice that was also identified by Schön, which he called "reflection-in-action". Schön contends that experienced professionals often cannot describe how they work to a non-professional. Much of their work is done in a spontaneous, intuitive manner. Their knowing is tacit, implicit in the actions of their work. Dreyfus and Dreyfus in Benner, Tanner and Chesla (1996) write that a beginner uses strict rules in their practice but an expert sees intuitively what to do. They do not reason. They do what experience has taught them works. Likewise in nursing, the beginner follows rules but the expert trusts intuition.

Benner, Tanner and Chesla (1996) contend that the phenomenology of everyday moral comportment or practice consists of unreflective, egoless coping that is a perceptual skill that first must be learned in a community tradition. The authors contend that these habits and skills are both received, created, and developed in dialogue with others and are amenable to correction even though they cannot be completely spelled out and comply with the demands of critical reasoning. The authors presume that in nursing, the ethical comportment, which a nursing student has already acquired in life, is modified by the new ethical demands of nursing practice. Novice nursing students have no prior experience of nursing knowledge thus are taught practice relevant knowledge. However, they do come to their practice with interpersonal skills and ethical concerns which they have acquired through prior work and personal experience and that are further developed and modified. The authors note that our culture teaches us the bases of moral comportment. A child first learns

respect, reciprocity, and relational skills. Later when they are able to understand they learn the rules for sharing and turn taking. The effectiveness of the learning will depend on how closely the child's experience matches rules. Respect for others, or ethical comportment, develops in complexity but is shaped by the social context. When adults learn a practice such as nursing, they similarly learn skilful, ethical comportment through imitation and questioning, skills, habits, and practices. Ethical expertise or experienced moral comportment is a skill learned through practice, narrative, and reflection in the context of community and culture. The authors argue that intuitive ethical expertise is in fact a superior form of ethical reasoning to the principles of justice. They claim the traditional western belief in detachment is in fact less mature than staying involved and refining one's intuition (p. 275). Briefly then, the expert nurse does not need to consult or think of rules and principles to guide practice but rather the expert nurse's ethical behaviour is intuitive.

Benner, Tanner and Chesla (1996) note that the ethic of care is the dominant nursing ethic found in stories of everyday practice.

> Care is defined as the alleviation of vulnerability, the promotion of growth and health, the facilitation of comfort, dignity, or a good and peaceful death, mutual realisation, and the preservation and extension of human possibilities in a person, a community, a family, or a tradition. ...an ethic of care must be learned experientially because it is dependent on recognition of salient ethical comportment in specific situations located in specific communities, practices, and habits (Benner, Tanner & Chesla, 1996, p. 233).

Benner, Tanner and Chesla (1996) recommend educational strategies to help nursing students to develop expert practice, expert practices which include ethical comportment. They recommend that: (1) students learn ruled-based activities and apply theoretical knowledge; (2) emphasis be placed on analytic clinical thinking,

recognising the contextual aspects of the situation; (3) as the student advances in analytic thinking they should learn how to individualise care. By knowing who the patient is they will be better to individualise the care for that patient; (4) the student should be guided in clinical knowledge development. They need to learn with the help of a skilled clinical teacher the relationship between textbook theory of signs and symptoms and qualitative patient's responses to illness; and (5) students need the opportunity to develop habitual practices and skills in reflection on practice.

To summarise then, in the early 1980s nurse theorists reject Kohlberg's moral reasoning theory and Rest's Defining Issues Test as inadequate to describe nurses' moral decision making. Nurse theorists begin looking for a moral framework that is more congruent with the reality of nursing. Interpretative phenomenology and the role of narrative is seen as way to gain an understanding of nursing concerns and practices (Carper, 1978, Cooper, 1991, Benner, Tanner & Chesla, 1996, Diekelmann, 2001). Diekelmann states that research-based innovation in nursing education is needed to address complexities in both educational and clinical environments. Conventional pedagogies are no longer adequate to educate nurses for careers in the technological complex, cultural diverse health care settings of society. Ironside (2001) states that the National League for Nursing Priorities for Nursing Education Research calls for educators to increase their pedagogic literacy to meet the challenges of the changing social, health care, and educational worlds, and to develop research-based pedagogies for nursing. Benner, Tanner and Chesla (1996) argue that nurses' expert ethical reasoning is an intuitive, mature form of moral reasoning. They recommend educational strategies to help nurses learn ethics through narrative practices. In the

next chapter I critique the competency concerned with the teaching and learning of ethics in nursing as outlined by the new nursing curriculum *Health: Nursing: Program of Study 180.A0*. I examine whether the new ethics competency recommends the use of narrative practices as an educational strategy to enhance the nursing students' knowledge of ethics and whether it has the potential for enhancing the ethical comportment of a student or novice nurse.

CHAPTER 4

EXAMINATION OF THE ETHICS COMPETENCY IN THE NEW CURRICULUM

The new Québec nursing curriculum was published in 2002 and is called *Health: Nursing: Program of Study 180.A0* (see Appendix C p. 96). It contains 22 competencies specific to nursing that a student must master to complete a college nursing program. Each competency has subsidiary elements, which specify the major steps in being able to perform the competency. The "learning activities" or as Vanier faculty have renamed them, the "learning outcomes" were a responsibility given to the individual colleges to develop as Vanier College has done. This document is called *Vanier College Nursing Curriculum 180.A0* (see Appendix D p. 99). There is one competency in the new curriculum for the teaching of ethics to nursing students: "to use the ethics and values of the profession to understand one's role". It has five elements each with four or five performance criteria.

The previous nursing curriculum *Nursing 180.01-96* contained 13 program objectives (see Appendix E, p. 103). Four of those objectives were subsumed in the new ethics competency. They stated that upon completion of the program, the graduate would be able to: (1) analyse ethical issues encountered in nursing with a view to determining an appropriate course of action; (2) demonstrate a social awareness of health-related issues in the community; (3) practice nursing within the legal parameters of the nursing profession; (4) practice nursing, utilising a set of values that are compatible with those articulated by the nursing profession. On comparison these program objectives are similar to four of the subsidiary elements of

the ethics competency. The element that does not appear in the previous objectives is "to become involved in maintaining and improving the quality of nursing care".

In the new curriculum the "objectives and standards" of the ethics competency states that the competency is based on *The Code of ethics of nurses*, and *Charter of Human Rights and Freedoms.* The students will need to study these works to understand the foundation of the competency and receive an introduction to nursing ethics. These documents will provide some direction and information. The work, which I think should be *The Outlook on the Practice of Nursing*, is not listed in the curriculum.

The Outlook on the Practice of Nursing is a document that is given to all nursing students when they enter a nursing program and every practicing nurse in Québec. It is recognised and used by nurses, teachers, administrators and researchers as a guideline to practice. This document is not mentioned in *Health: Nursing: Program of Study 180.A0* or in the *Vanier College Nursing Curriculum 180.A0* but when I corresponded with one of the consultant/advisors to the writing of the *Health: Nursing: Program of Study 180.A0*, she wrote that it was used as a reference. Unfortunately there is no bibliography or reference list to the new curriculum. Since, *The Outlook on the Practice of Nursing* is considered the "bible" by the OIIQ and the profession, I am surprised that it has not been named anywhere in the curriculum. Hopefully teachers will refer to it, as it is one document that actually is very beneficial to understand "one's role as a nurse" because it contains the values and standards of the profession.

The *Code of ethics of nurses* is a legal document, part of the laws and regulations that govern the practice of nursing in the province of Québec. As other codes of ethics it "stresses the importance of fulfilling one's duties that are inherently owed to patients and the importance of preserving the dignity and autonomy of each individual patient" (Burkhardt, M., Nathaniel, A., 1998, p. 32). The *Health: Nursing: Program of Study 180.A0* does not expressly name the *Code of ethics of nurses* as a document but does mention "nurses' ethical and legal obligations". The *Vanier College Nursing Curriculum 180.A0* does include it in the learning outcomes.

Codes of ethics are important for students to understand their obligations as a professional but have limited ability to influence their future behaviour. As Evers (1984) has said, use of codes of ethics for students' ethical instruction will not provide these future practitioners with a personal ethical philosophy and a process for ethical conflict resolution. Benner (1984) ascertains that beginner practitioners need rules to follow to function safely. "Beginners have had no experience of the situations in which they are expected to perform. Novices are taught context-free rules to guide action in respect to different attributes" (p. 20-21). Codes are needed to provide direction and guidance but do not encourage moral development.

The *Charter of Human Rights and Freedoms* is listed as a reference under the achievement context. This sets forth the basic legal and democratic rights of Québecers. If the student has not already been exposed to this document in their education, then it informs them of their own and their patients' basic rights as human beings. Considering that Vanier College students come from all corners of the globe,

some from countries considered less than democratic, it is valuable for them to know the laws in this province for their own protection as well as that of their patients.

The use of "personal reflections and discussions with colleagues" outlined, as an "achievement context" will provide the student nurse stories in which the context of ethical issues is discussed. Nurse theorists are advocating the use of reflective thinking and narrative in the personal development of the student and the nurse. Noddings (1984) and Benner, Tanner and Chesla (1996) propose interpretation of narrative as an educational innovation drawing on a long tradition of interpretive phenomenology, an interpretive approach for studying embodiment, world and caring practices through the study of text, which can be narratives of everyday life. The authors propose the use of (1) assignments that help students learn skills of gathering and interpreting clinical ethnographies or illness narratives, (2) students telling stories from their own practice (a) recognizing patient and family concerns, (b) communicating with patients, (c) reflecting on ethical comportment and (d) articulating experiential learning. (3) faculty stories from their own teaching practice can enhance faculty participation in pedagogical knowledge development (p. 316). Parker (1996) writes that storytelling is a common tool that humans use to make sense of themselves and the world around them. Stories are told and retold over and over in the same way an author writes multiple drafts of a manuscript in search of the meaning s/he wants to convey. This search for authorship is a process that enables nurses to better understand and define the substance of their moral identities (p. 223).

At Vanier College the third year teaching team has adopted a field notes approach as a way for nursing students to reflect on their clinical experiences. The

problem-solving tool, the nursing process, they are taught in first and second year of the program is very helpful to get the student to organize and focus their thinking in relation to patient care. However, by third year the students find the tool too prescriptive. The use of field notes not only encourages them to problem-solve, but also to include their thoughts and feelings about their clinical experience. At the end of the clinical day the teacher and nursing students meet for one hour in what is traditionally called post conference to reflect on the happenings of the day. This is an ideal time to discuss and reflect on any ethical concerns or issues that have surfaced during the day. Students get an opportunity to tell their story and to reflect on their personal beliefs and values. It appears that the practice of post conference is, as Parker (1996) asserts, a powerful pedagogical tool to promote moral judgement development in nursing students. Teachers must be careful to allow and accept students' interpretations and not make moral judgements. If a teacher becomes too critical of the students' thinking then the student is libel to become silent and not have an opportunity to develop their own moral reasoning skills. Brown and Tappan assert that the educator who cultivates an attitude of openness, receptivity, and active listening creates a milieu where both the student and teacher can learn moral lessons embedded in stories of moral conflict (cited in Parker, 1996). The authors contend that the process fosters the co-construction of new meanings and ways of thinking about moral problems; it can be a catalyst for change. Noddings (1984) writes that "throughout the process I would accept his attitude toward the subject, adjust my requirements in light of his interest and ability, and support his efforts nonjudgmentally. He must be aware always that for me he is more important, more

valuable, than the subject" (p. 174). Crowley (1994) states dialogue between student and teacher can only occur within the context of a trusting relationship. The teacher does not merely impart knowledge but rather she engages in a cooperative effort with the student that involves "...sharing and reflecting aloud". It is this sharing... the student is given the opportunity to achieve a greater degree of self-understanding (p. 79).

Griffith and Bakanauskas compared the student-instructor relationship to the therapeutic relationship of nurse-patient indicating that students could benefit from a relationship that provides open, honest communication based on trust and support, and that they could more easily learn the therapeutic approach essential to nursing (cited in Murray, 1989). Murray also states that caring attitudes, demonstrated by an admired, respected instructor who acknowledges student's strengths and weaknesses, are significant to students' relationship to nursing.

Studying codes of ethics, principles of justice, and professional standards of practice provide the student nurse and novice practitioner with the structure and guidelines she needs to begin her practice. But it is "personal reflection and discussion with colleagues" that is the most powerful and effective strategy that will help the students' moral development. It is included as the last method in the list of ways to achieve the competency and its significance could possibly be overlooked if a teacher is not familiar with the literature on nursing students' moral development. Nursing teachers could incorporate daily discussions of ethical issues at the end of each clinical day in post-conference as a strategy to enhance moral development not on the occasional basis as it usually is done.

The following are the subsidiary elements, which the MEQ developed: (1) to comply with professional values, (2) to assume responsibility for actions and decisions, (3) to understand the moral dimensions of the role, (4) to consider various professional situations from an ethical point of view, (5) to become involved in maintaining and improving the quality of nursing care.

To comply with professional values: The first subsidiary element is "to comply with professional values". The performance criteria refer to recognizing the nature and implications of the values of the nursing profession, personal values and how the two interact to effect personal practice.

> Our individual values influence how we respond to ethical issues and the decisions we make. A value is an ideal that has significant meaning or importance to an individual, a group, or a society. Because Canadian nurses work with and care for patients who represent a broad spectrum of cultural and religious perspectives, we must strive to clarify our own values, and respect and learn to understand those of others (Keatings & Smith, 1999, p. 16).

As a starting point by examining the *Outlook on the Practice of Nursing* and the *Code of ethics of nurses* the student will gain an understanding of the professional values that govern the practice of nursing.

Students come to the profession with their own values and might not be aware that the personal values they hold direct their behavior and practices. "Ethical relationships with others begin with self-knowledge and the willingness to honestly and appropriately express that awareness to others. Self-knowledge is an on-going, evolving process that requires a person to make a commitment to know the truth

about oneself" (Burkhardt & Nathaniel, 1998, p. 82). Keatings and Smith (1999) write

> Values clarification is an ongoing process that occurs through each individual interaction and team discussion or case conference. It is a process through which individuals come to understand the values they hold and the importance of these values relative to others. It thus facilitates mutual understanding. This process requires open discussion, communication, active listening, understanding, and mutual respect. It is enhanced if we share the same language and terminology in relation to ethical issues (p. 17).

An enhanced appreciation of personal and professional values prepares and guides the student nurse and novice practitioner in understanding how and why one reacts and responds the way one does in times when ethical issues arise and cause interpersonal conflict between patients, colleagues, or institutions. Kohlberg (1981) does not agree with values clarification. He argues that everyone has a different set of values and standards and even though participants go through the exercise of identifying their values it does not help in deciding which values are right. Kohlberg's solution was his six stage moral reasoning theory to determine individuals' the level of moral reasoning. But Kohlberg misses the point of values clarification. The purpose of values clarification is to become aware of the personal influences that effect one's own decision making. It does not determine that one value has priority over the other or one is more right than the other. When one is aware of one's own personal motivations one understands one's own behavior better. This in turn helps the decision making process because the parties involved are dealing with the issue rather than interpersonal conflict.

To assume responsibility for actions and decisions: The second subsidiary element is "to assume responsibility for actions and decisions". The first indicator of a moral behavior is to assume responsibility for one's actions. Benner, Tanner and Chesla (1996) contend that competent nurses' sense of agency is directly related to what they plan, predict, and control in their delivery of nursing care. They state that while one's sense of agency is never overtly visible, narrative accounts reveal the nurse's sense of self-efficacy, engagement, and sense of responsibility in the story. Is the nurse telling an account of events from the outside as an observer or from the inside as an active participant? Benner, Hooper-Kyriakidis and Stannard (1999) define agency as one's sense of and ability to act so as to influence the situation based on understanding what is needed and one's capacity to act. This includes but is not limited to decision making. The student nurse or novice practitioner has just begun to assume the role and is learning the scope and limits of practice. The clearer these boundaries are the easier it is for the nurse to gain confidence and assume responsibility for her practice. Historically nurses were taught to assume responsibility but in fact they had very little professional autonomy. Today this problem has been ameliorated somewhat. Nurses are given directives concerning which nursing acts as opposed to medical acts are considered within their domain of practice. Nurses who are clear where their professional boundaries lie are confident demonstrating their autonomy. The Nurses Act outlines the professional procedures nurses are allowed to perform independently, which nursing acts can be performed under physician's order only, and which acts are considered delegated acts, or acts that require supervision direct or indirect by a physician. The nurses' ability to assume responsibility relies somewhat on

assertiveness skills and self-confidence. However, self-confidence improves with increased clinical expertise and assertiveness can be learned if it is not a naturally held attribute. Assertiveness theory and skills are taught as part of self-development in the Vanier College nursing program.

A performance criterion under the element "to assume responsibility for actions and decisions" states by the "proper use of influence". There is a difficulty in knowing what "proper" might be. Yarling and McElmurry (1986) argued that because of institutional constraints nurses are often not free to be moral. They found that often nurses were not able to support their patients in situations where hospital and medical interests were overriding patient's dignity, wishes and rights. Because nursing education programs were a subculture of the healthcare system nurses were socialized in nonverbal and covert ways to conform to the limits of their decision making ability and power to affect the care of patients. Yarling and McElmurry called for a nursing ethic that would free nursing from the hegemony of the hospital. They called for social change within hospital institutions that brought a balance of power to nursing relative to the power of physicians and administrators. The authors encouraged nursing educators to not only teach their students to be patient advocates but to develop and teach a nursing ethic which would effect social change within the healthcare system. The authors argued that this reform was imperative if nursing was to maintain the integrity of the nurse-patient relationship, which is the moral foundation of nursing.

Bishop and Scudder (1987) responded to this challenge by deducing from the Yarling and McElmurry stance that they were advocating for a nursing ethic that

called for more nursing autonomy, accountability and decision making power. The authors argued that, in order to maintain the publics' trust, health care professionals must preserve harmonious working relationships and the legitimate authority of physicians and administrators must be respected. They argue that nurses by the daily exercise of competent practice and teamwork can claim legitimate authority and autonomy and bring about gradual change within the healthcare system. They believe that the focal question of a nursing ethic is not professional autonomy but the promotion of the well being of patients through communal decisions aimed at better patient care.

I would agree with Bishop and Scudder if it were the case that working relations in hospitals were always harmonious. Unfortunately they are not. It is often dependent on the work culture that has evolved in the particular hospital unit or department and the personalities involved. In my thirty-year nursing career I have seen the entire spectrum of professional relationships from hostile discord to productive collegial teamwork. As Yarling and McElmurry recognized patient care suffers when nursing recommendations are discounted. Nurses are unable to be the patient advocates that they are educated to be and they loose credibility in the nurse-patient relationship. When nurses, physicians and administrators respect their perspective team members' expertise the patients receive the best care possible.

Liaschenko (1993) responded that Bishop and Scudder located nurses and their work at pivotal junctions between physicians, patients, and hospital bureaucrats, which they called the in-between position. Liaschenko argued that nurses do the work

of sustaining the complex network of hospital relationships, but it is work that is often overshadowed, silenced, and made invisible.

The OIIQ has incorporated changes in Québec with the mandatory introduction of an institutional structure called the Council of Nurses. This is a structure within the hospital that fosters policy changes through nurse-generated studies and recommendations for improvements to practice within the institution. Every health care facility that employs nurses is obliged to have this structure. It has been recognized as an effective method to effect change within hospitals. Unfortunately, due to time and staffing constrictions the Council of Nurses does not always function to its maximum potential. The Nurses Act, which the OIIQ is currently bringing up to date in 2003, is also meant to ameliorate this problem but the general imbalance of power and unrecognized expertise still exist in the nursing profession. Thirty years ago hospitals were hierarchical systems with many layers of nursing and medical personnel. But directors of nursing sat on the hospital administration boards, which is not the case today.

Valerie Shannon (2000), who at the time of her speech was the Director of Nursing at The McGill University Health Centre (MUHC), reported on a study done on a group of hospitals in the USA to understand why in a midst of an acute nursing shortage, they were recognized as giving exceptional care. These "magnet hospitals" had many core organizational attributes, which Shannon reported were:

- The nurse executive was a formal member of the highest decision making body in the hospital which signified the high priority the hospital administrators placed on nursing.
- Nursing services were organized in a flat organizational structure with few supervisory personnel, rather than a pyramid structure composed of many layers.

- Decision making was decentralized to the unit level, giving nurses on each unit as much discretion as possible for organizing care and staffing in a manner most appropriate to the needs of their patients.
- The administrative structures supported the nurses' decisions about patient care.
- Good communication existed between the doctors and nurses. (Shannon, 2000, p. 6)

Nurses are better educated and have a much stronger voice than thirty years ago but nursing has lost ground in relation to institutional decision making power. Shannon resigned from her position as the Director of Nursing of the MUHC in the fall of 2002. If nurses do not have the institutional autonomy and power to effect the day to day practice of their profession then as Yarling and McElmurry (1986) said: nurses are not free to be moral.

The "proper use of influence" can be criticized for introducing false hope to future nurses and setting them up for failure. But if sensitized to weaknesses and failures of the health care system in promoting the health of citizens and taught assertiveness and the importance of political strategies nurses can effect change. The Canadian Nurses Association commissioned American journalists Bernice Buresh and Suzanne Gordon to write their book *From Silence to Voice: What Nurses Know and Must Communicate to the Public* (2000). Recognizing that nursing can potentially influence positive change to the health of Canadians, the federal association saw the need to write a guide for nurses on how to use the media, use public influence and debate effectively to their advantage. The "proper use of influence" is a performance criterion that reflects current nurse leaders' political aspirations to educate nurses to effect change.

To understand the social dimensions of the role: The third subsidiary element in the *Health: Nursing: Program of Study 180.A0* curriculum is "to understand the moral dimensions of the role". In the *Vanier College Nursing Curriculum,* which was developed from the earlier unofficial 2000 version this element is worded "to understand the social dimensions of the role" (see Appendix D, p. 100). The writers of the *Health: Nursing: Program of Study 180.A0* changed the word "social" to "moral" (see Appendix C, p. 96) yet the word "social" has a broader scope and better reflects the performance criteria that accompany the element. I will discuss the element in terms of the "social dimensions of the role". The "dimensions of the social role" refers to nurses' role in health promotion, maintenance and improving a person's health and quality of life. Health promotion is a major principle of the nursing profession put forward in *The Outlook on the Practice of Nursing.* It is based on a belief that people aspire toward health and that nursing can effect change and influence people to adopt healthier life styles. Health care has and will continue to change because of new technologies and a constant pressure to reduce health care cost. The Pew Health Professions Commission (1995) called for nursing to advocate for public policy that promotes and protects the health of the public. The National Nursing Competency Project (1997) expects nurses to support professional efforts in nursing to achieve a healthier society. Health promotion is of major interest to government bodies in Canada trying to save health care dollars. Our current health care system was built on the premise of curing disease. Nursing has been very effective at disease prevention and more recently health promotion practices.

There are some nursing schools that design their curriculum from a health promotion perspective. In British Columbia one nursing faculty reports that:

> An element that has permeated our curriculum discussions is the centrality of a health promotion perspective in nursing. It became instantly apparent that in order to meet the demands of the future health care system, radical changes would need to occur in nursing education. Basing nursing curricula on health promotion principles provides nurses with an opportunity to shift from a medical model to one that truly reflects nursing. (Hills, et al, 1994, p. 222).

Pender, Murdaugh and Parsons discuss the idea of health promotion as a means to eliminate health disparities among vulnerable populations (cited in Haynes, 2002). Its focus is to promote health, not help cure disease, and potentially change the health of a population. The element "to understand the social dimensions of the role" contains a potentially influential element to teach nursing students their social responsibility to improve the health of not only the patients under their direct care but on a greater scale the population as a whole. Government bodies have been encouraging the shift of health care to the community and home. Since 1990 Québec has instituted major efforts to alter the delivery of health care with the expansion of "le virage ambulatoire", ambulatory care in the province. Health promotion practices compliment this goal by improving the health of citizens thereby reducing the need for acute hospital care.

The third performance criterion "to understand the social dimensions of the role" also states that the student nurse should recognise one's own responsibility in regard to the protection of a person's rights, values and wishes. Keatings and Smith (1999) state that,

> A right is a claim or privilege to which one is justly entitled, either legally or morally. Legal rights make it explicit an individual's claim

> to such entitlement. Another aspect of rights is autonomy, or the right to act on one's own, free of interference or control of the state or others. The right of patients are made explicit and clear through standards contained in professional codes of ethics (p. 264).

Moral rights include such aspects as the right to be treated with respect, to be informed of risks of treatment, the right to information about treatment resources, and the right to confidentiality. But it is evident that the curriculum advocates that nurses go beyond what the law or the code of ethics require by saying that a person's values and wishes should be protected. Nurses are taught how to establish a nurse-patient relationship and within this relationship, the nurse gets to know the patient and learns the context of the patients' situation. The wording of this performance criterion would reflect that the curriculum has incorporated concepts from Noddings's theory of care and Gilligan's ethics of care. To know patient's wishes implies that a respectful and effective nurse patient relationship must be established. The nurse-patient relationship called the therapeutic process in the *Outlook on the Practice of Nursing* stipulates under client outcomes that "clients who learn that they suffer from a condition with a bleak prognosis, that they are in a terminal stage of an illness or that death is imminent have the opportunity to express their emotions, feelings and desires. Family members who are experiencing a loss have the same opportunity" (OIIQ, 1996, p. 16). The criterion illustrates that the competency's design is coordinated with the principles of the nursing professions' standards.

To consider various professional situations from an ethical point of view: The fourth element of the competency specifies that the student nurse must learn "to consider various professional situations from an ethical point of view". This element

refers the nurse becoming familiar with the ethical decision making process. Nurses attempt to resolve ethical dilemmas using a problem-solving frame of reference similar to both the nursing process and scientific inquiry. There are many models of the decision making process. Depending on the nurses' moral point of view various models of decision making could be used to solve an ethical dilemma. In order to avoid confusion educators generally pick one model to incorporate into their curriculum so that nursing teachers and students use the same decision making process throughout the three year program. It is considered more desirable that students learn one model well rather than get confused by learning several models poorly. A problem arises when faculty disagrees on which model to choose. Each model has its advantages and disadvantages. The *Health: Nursing: Program of Study 180.A0* has not prescribed a model but has left that to the local colleges.

Some models incorporate elements from both the ethics of justice and the ethics of care. For example some of the steps in the model proposed by Keatings and Smith (2000) includes the steps "gather the facts", "clarify values", "identify ethical principles" and "clarify legal rules".

> **Gather the Facts** asks: What is the patient's diagnosis? Prognosis? Age? What is the patient's cultural background and religion? Are there family or significant others? What is their relationship? Who is involved in the patient's care? Is the patient competent? Has a proxy decision maker been appointed? Is there a living will?
>
> **Clarify Values** asks: What are your beliefs about the situation? What are the values of other members of the team? Of the patient and family? Will the cultural and religious background influence what is happening and who should be involved in dealing with this problem?
>
> **Identify Ethical Principles** asks: Which principles apply to this situation? Are any of these principles in conflict? Does one principle have priority over the others?

> **Clarify Legal Rules** asks: Are there any legal rules that govern this situation (as in release of confidential information)? (p. 42)

By including the context, the background, the culture, and the relationship between the affected parties, the model reveals whether or not an ethics of care has been incorporated into the decision making process. Identifying principles and legal rules relates to the ethics of justice. As stated earlier nurses need rules and guidelines at the beginning of their career to help guide their practice. By carefully examining the various decision making models faculty can choose a model that they estimate best fits the educational goals and philosophy of their nursing program. Therefore the element "to consider various professional situations from an ethical point of view" allows nursing teachers to incorporate the ethics of care to a greater or lesser degree depending on the ethical decision making model they choose.

To become involved in maintaining and improving the quality of nursing care:

Element five of the competency specifies "to become involved in maintaining and improving the quality of nursing care". This element derives from a major descriptive statement delineated in the *Outlook on the Practice of Nursing* under professional commitment. The principle states

> The nurse demonstrates that her nursing practice is based on sound scientific knowledge that she updates continuously. The nurse is committed to her profession and exhibits solidarity with other nurses. She builds her professional identity through her various nursing activities. She recognizes the importance of interdisciplinarity and the need to cooperate with organizations within the community (OIIQ, 1996, p. 22).

The elements of practice outlined in the *Outlook on the Practice of Nursing* correspond to element in the *Health: Nursing: Program of Study 180.A0*. This element incorporates the goals of life-long-learning and social responsibility. Benner, Tanner and Chesla (1996) best describe social responsibility to the profession.

> These discussions are most logically placed in courses on "professional development" For this to work effectively, clinical supervision groups must be supportive of learning that accepts rather than blames the student for misjudgments. Students can begin to learn the collegiality that is required in a discipline where the knowledge for practice is shared. It also may represent a shift—from the individual competitiveness that characterizes some academic environments, to group support and shared responsibility for furthering the abilities of the learner and the care of the patient. (p. 327-328)

The authors have incorporated Noddings description of a caring teacher as one who receives the student, for the interval of caring, completely and nonselectively. When a teacher asks a question of a student she not only receives a response, she seeks involvement from the student, the student is infinitely more important than the subject matter. So as with previous elements, this element "to become involved in maintaining and improving the quality of nursing care" reflects professional values. As Benner, Tanner and Chesla (1996) contend this is best covered under a professional development segment of the course and certainly moral development is part of professional development.

Theory of ethical decision making taught in fifth semester: A major criticism of the new curriculum is that, apart from being introduced to the role of the nurse from a legal, social and philosophical perspective, the theory of ethical decision making has

been placed in the fifth semester in one forty-five hour block. In the previous curriculum there were thirty-six hours of ethics content distributed evenly throughout the six semesters of the program. The students are informally exposed to ethical issues throughout the nursing program in both classroom and clinical settings. The belief is that students are able to address ethical considerations with increasing sophistication as they mature in their nursing experience. Vanier College like other nursing programs had the option of choosing the written course format as it was designed by the writers or to rearrange the competencies. Due mainly to time constraint Vanier College chose for the most part to accept the prescribed format, the consequence being that the theory of ethical decision making was left in one forty-five hour block in the final year. This goes against the principles of teaching and learning, students should be encouraged to build their ethical and moral development on previous learning. The theory of ethical decision making would have been better divided into smaller units consisting of the individual elements over the six semesters. This could still be changed at a later time. However, once a curriculum is adopted, teachers get committed to the courses they are teaching and changes are difficult to make. But the teaching of the ethics content in one block near the end of the nursing students' education is definitely of poor design. Needless to say, teachers will continue to guide their students to become ethically competent throughout the three years of their nursing education. Although ethical and moral development is included under only one competency with five subsidiary elements its scope is broad and vast. Logically the *Outlook on the Practice of Nursing* can be used to provide direction and background to this competency as many of the elements relate to the principles and

standards of the profession. This competency can be taught on many different levels of understanding depending on the teacher's appreciation and understanding of the acquisition of ethical comportment. Personally I think a bibliography to the curriculum, and the competency in particular would be helpful for a teacher to be able to gain a grasp of the subtleties found in this competency. Teachers are pressed for time, which makes it difficult to do individual reading and research on a topic such as the teaching of ethics if it is not their personal teaching responsibility. It would be unfortunate to merely continue previous teaching strategies to the new competency due to a lack of direction. A bibliography or reference list would help focus and direct teachers' personal reading on the topic. The MEQ has not been prescriptive and allowed the teachers the freedom and scope to develop the learning outcomes to the competency as they think appropriate to their individual program at the local college level. But then, a bibliography is not prescriptive it merely acknowledges sources used. The new curriculum is not based on original research or thinking. Sources should be acknowledged. Quite remarkably, no one seems concerned. Not once have I heard teachers complain that the new curriculum does not contain a bibliography.

CHAPTER 5

CONCLUSION

Preliminary Studies to the Curriculum

This study set out to examine the development of nursing ethics. In the 1970s and 1980s nursing was heavily influenced by the work of Kohlberg. Nurse educators recognizing the need to teach ethics used Kohlberg's moral reasoning theory to evaluate the level of nurses' ethical development. The results indicated that nurses usually reasoned at a conventional level of moral reasoning, at the level of a high school student. Age and experience in the profession seemed to make it worse. There was a call for the improvement of ethics education for nurses. But the discouraging results related to nurses' moral reasoning ability did not correspond to the characteristics of nurses. They were intelligent, caring people. Nurse researchers began to question the use of the scientific method as a research tool to develop nursing theory and nursing ethics. Nursing is a caring profession, caring is its foundation. Nurse theorists examined the theory of caring and the ethics of care in relationship to nursing. With the advent of Carol Gilligan's *In a Different Voice* nurses realised they had to develop their own theories based on their own narratives. An ethic of care was more congruent with the nature of the nurse-patient relationship and the goals of the nursing profession. Nurse researchers are developing nursing theories based on nurses' ways of knowing. Nurses display a fundamental commitment to an ethic of justice in their practice but an ethic of care provides the framework, which determines the relationship with the patient.

The principles and rules of justice in relationship to nursing can be learned through the use of case studies, examining codes of ethics and charter of rights and freedoms. However, nurses develop moral reasoning ability and comportment through discussion and storytelling. Student nurses' abilities and self-confidence increases with experience but also through dialogue with other nurse mentors and teachers. A wise and caring nurse teacher can have a profound effect on a novice nurse. Moral reasoning and comportment can be learned through a caring student teacher relationship. A caring student teacher relationship will develop a caring practitioner.

The health care and social services sector underwent major changes during the 1990s. The changing needs and expectations of the population, new medical practices, recent scientific and technological developments, along with major budgetary constraints resulted in a reorganisation of the health care sector. August 1996 the Ministère de l'Éducation du Québec (MEQ) published the results of an exploratory survey *Soins infirmiers – Étude préliminaire* to determine the future nursing needs of the health care sector and a change in nursing education. To encourage nurses to further their education and facilitate career mobility the MEQ sought to integrate the various nursing education programs. Survey results recommended a revision to assure that nursing education would meet future needs of the workplace. October 1996 the health sector of the MEQ held a workshop to form another committee to examine the needs and requirements for future nursing education in the province. This study became one of the working documents for a new nursing curriculum. The study was conducted with the participation of fifteen nurses from four different regions of Québec and representing a cross section of

different sectors of the health care system. A working document *Santé, Infirmière diplômée et infirmier diplômé du collégial, Rapport d'analyse de situation de travail* was completed by the end of November 1996. By October 1998 a working document called *Santé, Projet de formation en soins infirmiers* had been written.

Health: Nursing: Program of Study 180.A0

By fall 1999 the colleges received a working document by which to develop their own learning activities and develop the program approach. By August 2000 the first nursing students entered the new program. The final new nursing curriculum document was published by the MEQ in 2002 and is called *Health: Nursing: Program of Study 180.A0.* It does not contain a bibliography. Examination of these preliminary surveys and studies indicate that the new curriculum was based on needs assessment of the workplace. The bibliography of *Soins infirmiers – Étude préliminaire* indicates extensive preliminary surveys were done in the health care sector to assess the wants and needs of the different regions and levels of health care in the province. There was a big push toward ambulatory care in the province and there would have to be a shift of nurses from the acute hospital setting to the community. The published works by the OIIQ that were included in the study concerned the functions and competencies of nurses required for ambulatory care. The MEQ studies were also evaluating the Collège d'enseignement général et professionnel (CÉGEP) nursing programs and survey results of employers' level of satisfaction with the performance of diploma level nurses upon hiring.

I emailed one of the consultant-advisors to the two writers of the curriculum asking for a bibliography or reference list. I also indicated that I wanted to critique the competency related to the "use of ethics and values of the profession to understand ones role". She responded by saying that she was not sure if she could help me but she provided me with the name of three documents that were used to write the ethics competency. They are the *Outlook on the Practice of Nursing*, the *Projet national sur les compétences infirmières (National Nursing Competency Project) and the Analyse de situation de travail*. Every nurse in Quebec has a copy of the *Outlook on the Practice of Nursing* and I have my copy so that was easy to obtain. The OIIQ has a copy of the *Projet national sur les compétences infirmières* and the McGill Health Sciences Library has a copy of *National Nursing Competency Project*. The last document proved to be more difficult. After numerous inquiries and the unsuccessful help of four librarians from major Montréal libraries I serendipitously obtained a copy from a colleague whom had filed it upon receiving it from a retiring teacher. It was then that I discovered a more complete name to the document as *Santé, Infirmière diplômée et infirmier diplômé du collégial, Rapport d'analyse de situation de travail.* Of the three documents only the *Outlook on the Practice of Nursing* contains a bibliography.

I also wrote a writer of the new curriculum, who kindly answered my email but also said she wasn't sure she could help me. She did provide me with a list of works she consulted to write the ethics competency. A work she listed but not cited elsewhere is *Expertise in Nursing Practice* by Benner, Tanner, and Chesla (1996). This work was unknown to me before this study. It is a comprehensive work, an

excellent source for a nursing teacher to grasp the accumulative body of knowledge related to expert practitioners, how they develop their expertise and how this relates to caring, ethics in nursing and nursing education. This is a reflective work that incorporates the evolvement of a nursing ethic and how an ethic of care is integral to nursing education and the nursing profession. It compiles the latest research of the humanistic tradition into nursing education. This book includes one chapter on nursing education. There is only one bibliography in all of the preliminary documents to the new curriculum, which is *Soins infirmiers – Étude préliminaire.* The bibliography reveals that the MEQ is interested in assuring that nurses will be able to satisfy the needs of the workplace but little concern about the theoretical context or philosophy of nursing education. The writers of the curriculum were however influenced by the current nursing theorists who are concerned with effective nursing education strategies.

Neither the consultant nor the writer mentioned a preliminary document to the MEQ. I discovered the title Soins *infirmiers – Étude préliminaire* in a bibliography of a study done by the Québec Hospital Association named the *Identification des compétences requises par les infirmières et le personnel d'assistance en fonction des besoins des clientèles du réseau de la santé et des services sociaux*. Later I had it retrieved by a librarian at the MEQ through the help of a librarian at Québec Hospital Association. I include this information to illustrate the difficulty in obtaining and evaluating original sources. It would not be obvious to a teacher who wanted to do background reading on the new curriculum that these above-mentioned documents

had been used to write the competencies and only one the *Outlook on the Practice of Nursing* would be easily accessible.

The *National Nursing Competency Project* (NNCP) mentioned by the consultant was a three-year survey managed under the Executive Director of the Canadian Nurses Association (CNA) and funded by Human Resources Development Canada. The NNCP "was initiated in 1994 in response to the rapidly changing health care environment and recognition by nursing regulatory bodies for the need to plan for the future" (CNA, 1997, p. 1). The objectives were to compile a national database describing competencies and contexts of practice for entry-level practitioners to ascertain the future needs of the nursing profession in Canada. The final report was released in 1997. The consultant mentioned it in her email but I have not seen it referenced in any subsequent documents or the writer's list of consulted works. The MEQ did conduct the *Santé, Infirmière diplômée et infirmier diplômé du collégial, Rapport d'analyse de situation de travail* described above which had similar objectives and process. These surveys partially complete the Ironside (2001) call for educators to meet the challenges of the changing social, health care and educational worlds. I say partial because the surveys assessed for the skills the nurse of the future would require to meet society's health care needs but did not address the educational challenges. How will the MEQ respond to the current nursing teacher shortage? How will they help teachers update their education and skills to meet the demands of the new curriculum? How will they find clinical facilities for student experiential learning? How will they address the learning needs of a diverse student nurse population?

One copy of the new curriculum

By fall 2002 the Ministère de l'Éducation sent each college nursing program in Québec one copy of *Health: Nursing: Program of Study 180.A0*. As mentioned earlier it contains no bibliography. Schools had started to implement the new curriculum by fall 2000 and were using their own unofficial versions that were very similar to the final document with the addition of the locally developed learning outcomes for each competency. Vanier College paid for the cost of providing each nursing teacher with her own copy of the *Vanier College Nursing Curriculum*. It is perhaps a minor point but I think it illustrates a lack of regard for nursing teachers that the MEQ did not send each nursing teacher her own copy of the final version of *Health: Nursing: Program of Study 180.A0*. As nurses are expected to "demonstrate an interest in the development of the discipline and innovative approaches to nursing" as stipulated in the new curriculum then the nursing teachers should also be given the tools and means to do the same. The MEQ should have assured that the curriculum contained a bibliography and reference list for self-development and educational purposes for the teachers.

Resources to develop the new curriculum

Thompson and Thompson (1989) wrote that if nurses were to understand the principles of ethics and carry them out in their work, then nursing faculty are required who understand both ethical theories and their application to nursing. *Expertise in Nursing Practice* by Benner, Tanner, and Chesla (1996) is an excellent teacher reference not only for the ethics competency but an excellent reference for nursing education in general. It provides a theoretical background to the ethics competency.

Evers (1984) called for a greater commitment from nurse educators to expand and enrich the teaching of ethics to nursing students. She argued for a humanistic approach to the teaching of nursing so that students could comprehend how the loss of freedom and autonomy due to illness affects patients. She saw the need for faculty to encourage development of the student's own sense of self. Evers recognized that a nurse's clinical judgements were based on past experiences and present concepts, feelings, and values about self, others, and the meaning of human life. She stressed that teachers should encourage the development of the wholeness of the student and to serve as mentors for students in their ethical decisions. Evers also stated that school administrators must provide time and finances to enable faculty to be more prepared in this area.

Vanier College did provide a quarter-time teacher to design and write the *Vanier College Nursing Curriculum* and every subsequent semester a quarter-time teacher was employed to write the performance criteria for next semester. All except this current semester not due to unwillingness on the part of Vanier College administrators but the unavailability of qualified nursing teachers to hire. The nursing shortage has begun to effect the teaching cohort. The MEQ also provided funds to renovate and enlarge existing nursing laboratories.

Competency-based curriculum

The new curriculum is competency-based. The MEQ responded to the findings in *Santé, Projet de formation en soins infirmiers* which called for future nurses to be prepared to respond to the needs of a rapidly changing health care

system, nurses that would be able to function in a variety of settings. There have been many similar studies performed to help determine the future skills and talents required of nurses such the *National Nursing Competency Project* and the Pew Health Professions Commission. One of the driving forces is the current shortage of nurses that has been predicted to get only worse in the future. With a competency-based program students who have already acquired competencies in previous studies can apply them toward their Diplôme d'études collégiales (DEC) in nursing. The other purpose is to integrate the college-educated nurse into a new two-year DEC-baccalaureate program of study ending with a university degree. This was made possible because universities also have developed competency-based nursing programs. This brings Québec in line with the majority of Canadian provinces who already had integrated college university programs and have made the baccalaureate nursing degree the nurses' entry point to practice.

Student nurses enter nursing education from a variety of backgrounds. There are still a few that come directly out of high school and enter a CÉGEP nursing program, but others are former CÉGEP graduates that are returning for a career change, foreign educated students that have met the equivalency requirements to enter CÉGEP, nursing assistants who want to upgrade their career, and foreign nurses required to repeat their professional education because their education is not considered equivalent here in Québec. Nursing programs can no longer assume a consistent educational background from their students. Competency-based programs "emphasizes outcomes in terms of what individuals must know and be able to do, and allows flexible pathways for achieving the outcomes" (Tanner, 2001, p. 387).

According to Tanner competency-based programs have their critics. They are seen as "excessively reductionistic, rigid, and overly prescriptive. When behaviourism is the underlying framework, Tanner agrees but in "other models competence is viewed as a complex combination of knowledge, attitudes, skills, and values displayed in the context of task performance. Interpreted broadly, competence is not trained behaviour but thoughtful capabilities and a developmental process" (p. 388). The *Health: Nursing: Program of Study 180.A0* is an example of the latter. It has been designed as a guideline but the individual college has ample room for interpretation and flexibility.

> Tanner (2001) contends that many questions remain. What are the various competency models? How have they been used in higher education generally and in nursing specifically? How are faculty able to make the transition to new faculty roles required of these models? What tools are available for competency assessment and are they valid and reliable predictors of performance in practice? What pedagogical practices support attainment of competencies? What models of clinical learning have evolved? What evidence do we have for their effectiveness (p. 388).

January 2000, the OIIQ adopted a new professional performance examination called Objective Structured Clinical Examinations (OSCE) to more accurately measure competencies. Currently the members of the Nursing Examination Committee at Vanier College have asked some of the same questions as Tanner poses above. In December 2002, one of the committee's meetings was used exclusively to do a CINAHL (Cumulative Index of Nursing and Allied Health Literature) search to try to find if OSCE results were an indicator of valid and reliable predictors of performance in practice. The introduction of OSCE as a professional accreditation examination although long an accepted practice for medical students is an innovative

and unique method of examining nursing students in North America. The committee was unable to find any useful information in the literature search. Our committee examined only one aspect of the evaluation process but it is evident that Tanner poses valid concerns for nurse educators in this province.

Further research

Further research is needed for nursing teachers to better understand how competencies are learned. As Tanner (2001) asks what pedagogical practices support attainment of competencies? Upon reading and examining the literature I have a better understanding how nurses learn "to use the ethics and values of the profession to understand one's own role". If I had not undertaken this thesis I would have never become aware of the development of the ethics of care or the importance of narrative practices to the learning of ethics in nursing. If it had not been for the inquiries made to the consultant-supervisor or the writer I would never have known the sources used to write the ethics competency. I still do not know the sources used to write the other 21 competencies of the curriculum. Furthermore I would never have been aware of the learning of ethical reasoning and moral comportment referred to in *Expertise in Nursing Practice* by Benner, Tanner, and Chesla and it relevance to the ethics competency. I have now shared this with my colleagues but the ethics competency is only one out of twenty-two. What other pieces of information are teachers missing? Why does it take someone doing research to discover this resource? Would it not be helpful as well as respectful to provide teachers with a bibliography or reference to the new curriculum? Why does the *Soins infirmiers – Étude préliminaire* contain a

bibliography but not *Health: Nursing: Program of Study 180.A0* Is it an oversight? Should preliminary documents not be made more readily available to the teaching profession? The professional body, the Ordre des infirmières et infirmiers du Québec did not have a copy of the preliminary study in their document centre. I find that extraordinary. The MEQ conducted surveys to discover society's health care needs but to my knowledge they did not conduct surveys of nursing schools to discover student or teacher needs. Vanier College's diverse student population may have learning needs that are not being met by the new curriculum. Students from different cultural backgrounds undoubtedly have different views on ethical issues. Are these views being considered in the new curriculum? Are Vanier College nursing program's pedagogical practices helping nursing students learn the new competencies? These are all questions that could lead to further research. It has been a long and winding road but immensely rewarding and illuminating.

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APPENDIX A

KOHLBERG'S STAGES OF MORAL DEVELOPMENT

Kohlberg's Stages of Moral Development

Level I. The Preconventional Level has an egocentric focus and includes two stages. In Stage 1, *The Stage of Punishment and Obedience,* rules are obeyed in order to avoid punishment. In Stage 2, *The Stage of Individual Instrumental Purpose and Exchange,* conformity to rules is viewed to be in one's own interest because it provides for rewards. Fear of punishment is a major motivator at this level.

Level II. The Conventional Level is focused more on social conformity and includes two stages. In Stage 3, *The Stage of Mutual Interpersonal Expectations, Relationships, and Conformity,* concern about the reaction of others is a basis for decisions and behaviour, and being good in order to maintain relations is important. In Stage 4, *The Stage of Social System and Conscience Maintenance,* one conforms to laws and to those in authority because of duty, both out of respect for them and in order to avoid censure. For persons in this level, fulfilling one's role in society and living up to expectations of others are important, and guilt is more of a motivator than fear of punishment noted in Level I.

There is a transitional phase between Stages 4 and 5 in which emotions begin to be recognized as a component of moral reasoning. This transition includes an awareness of personal subjectivity in moral decision making and a recognition that social rules can be arbitrary and relative.

Level III. The Post-Conventional and Principled Level has universal moral principles as its focus. It includes two stages. In Stage 5, *The Stage of Prior Rights and Social Contract or Utility,* the relativity of some societal values is recognized, and moral decisions derive from principles that support individual rights and transcend particular societal rules such as equality, liberty, and justice. In Stage 6, *The Stage of Universal Ethical Principles,* internalized rules and conscience reflecting abstract principles of human dignity, mutual respect, and trust guide decisions and behaviours. Persons at this level make judgements based on impartial universal moral principles, even when these conflict with societal standards.

APPENDIX B

GILLIGAN'S STAGES OF MORAL THINKING

Gilligan's Stages of Moral Thinking

Phase 1. In this phase, *the concern for survival,* the focus is on what is best for the self and includes selfishness and dependence on others. The *transition* to Phase 2 involves an appreciation of connectedness and that responsible choices take into account the effect they have on others.

Phase 2. The phase of *focusing on goodness* includes a sense of goodness as self-sacrifice in which the needs of others are often put ahead of self and there is a sense of being responsible for others so that one is regarded positively. This focus on goodness reflects an awareness of relationship with others and may be used to manipulate others through a "see how good I've been to you" attitude. In the *transition* to Phase 3 there is a shifting from concern about the reactions of others to greater honesty about personal motivation and consequences of choices and actions. Responsibility to self is taken into account along with responding to needs of others.

Phase 3. The phase of *the imperative of care* reflects a deep appreciation of connectedness, including responsibility to self and others as moral equals, and a clear imperative to harm no one. One takes responsibility for choices, in which projected consequences and personal intention are the motivation for actions rather than concern for the reaction of others.

APPENDIX C

HEALTH: NURSING: PROGRAM OF STUDY 180.A0

COMPETENCY 01QF

CODE: 01QF	
OBJECTIF	**STANDARD**
Statement of the competency To use the ethics and values of the profession to understand one's own role.	**Achievement context** • Based on the: - policies and practice standards set by the OIIQ - nurses' ethical and legal obligations - Charter of Human Rights and Freedoms • Using: - nursing care assessment tools - reference materials - personal reflections and discussion with colleagues.
Elements 1. To comply with professional values.	**Performance criteria** 1.1 Recognition of the nature and implications of the values of the profession. 1.2 Establishment of a judicious link between one's own values and those of the profession and the workplace. 1.3 Desire to harmonize one's own values with those of the profession and the workplace. 1.4 Demonstration of behaviours and attitudes compatible with professional values.
2. To assume responsibility for actions and decisions.	2.1 Demonstrate of autonomy and discernment in carrying out duties. 2.2 Reliability in accomplishing work. 2.3 Accountability for one's own actions and decisions. 2.4 Proper use of influence.
3. To understand the moral dimensions of the role.	3.1 Identification of nurses' contribution to health care. 3.2 Recognition of one's own responsibility in regard to the protection of a person's rights, values and wishes. 3.3 Demonstration of interest in improving the population's health status.

CODE: 01QF	
4. To consider various professional situations from an ethical point of view.	4.1 Identification of the ethical dimensions of the professional situation. 4.2 Demonstration of openness and respect for points of view stated. 4.3 Appropriate contribution to discussions. 4.4 Clear differentiation between ethical problems applicable to his/her area of responsibility and those of other professionals. 4.5 Reasoned justification of his/her ethical position.
5. To become involved in maintaining and improving the quality of nursing care.	5.1 Identification of nursing care situations requiring improvement. 5.2 Demonstration of interest in the development of discipline and innovative approaches to nursing. 5.3 Readiness to share knowledge. 5.4 Search for ways to improve the quality of one's own professional actions.

APPENDIX D

VANIER COLLEGE NURSING CURRICULUM 180.A0

COMPETENCY 01QF

UNIT 1: Nursing

The Nursing Profession

<table>
<tr><td colspan="2">Competency 01QF: To use ethics and values of the profession to understand ones role.</td></tr>
<tr><td>Achievement Context
Based on the:
1. policies and practice standards se by the OIIQ;
2. nurses' ethical and legal obligations;
3. Charter of Human Rights and Freedoms
Using:
4. nursing care assessment tools;
5. reference materials;
6. personal reflections and discussions with colleagues</td><td>Learning Context
• In the classroom and seminar setting.
• Using simulated and real situations from the life experiences of persons of all ages.
• Based on realistic and real clinical data, policies and practice standards set by the OIIQ, nurses' ethical and legal obligations and the Charter of Human Rights and Freedoms.
• With the help of assessment tools, and reference materials.</td></tr>
<tr><td>OBJECTIVE/STANDARD</td><td></td></tr>
<tr><td>Element 1.
To comply with professional values.

Performance Criteria
1.1 Recognition of the nature and implications of the values of the profession.
1.2 Establishment of a judicious link between one's own values and those of the profession and the workplace.
1.3 Desire to harmonize one's own values with those of the profession and the workplace.
1.4 Demonstrate of behaviours and attitudes compatible with professional values.</td><td>To comply with professional values, the student will:

1. Describe the means to ethical nursing practice (Code of Ethics: OIIQ Code of Ethics and Canadian Nurses Association Code of Ethics).
2. Describe the purpose of the codes of ethics in nursing.
3. Identify professional values and moral principles inherent in the Codes of Ethics in Nursing for OIIQ and CNA.
4. Describe the need for ethical practice and skill by the nurse in contemporary health care.
5. Identify own values and integrate them with those of the profession and the workplace.
6. Exhibit ethical conduct in the capacity of a professional nurse towards clients, the public and the nursing profession.</td></tr>
<tr><td>Element 2.
To assume responsibility for actions and decisions.

Performance Criteria
2.1 Demonstration of autonomy and discernment in carrying out duties.
2.2 Reliability in accomplishing work.
2.3 Accountability for one's own actions and decisions.
2.4 Proper use of influence.</td><td>To assume responsibility for actions and decisions, the student will:

1. Demonstrate autonomy in nursing practice, based on a thorough understanding of the knowledge, competence and preparation needed to fulfill the nursing role.
2. Perform nursing activities in a timely and thorough manner.
3. Take responsibility for decisions made for self and on behalf of the person.
4. Use an organized method of decision-making based on thorough knowledge and understanding of professional values.
5. Act as an advocate when the person's rights require protection.
6. Engage in on-going self-evaluation of one's competence.</td></tr>
</table>

Element 3. To understand the social dimensions of the role. **Performance Criteria** 3.1 Identification of nurses' contribution to health care. 3.2 Recognition of one's own responsibility in regard to the protection of a person's rights, values and wishes. 3.3 Demonstration of interest in improving the population's health status.	To understand the social dimensions of the role, the student will: 1. Describe the role of the nurse in the promotion, maintenance and improvement of a person's health and quality of life. 2. Acknowledge the nurse's responsibility to collaborate with the person in decision-making related to health issues. 3. Prevent the use of coercive measures that could influence the person's decision-making. 4. Describe a method of values clarification. 5. Engage in values clarification for self and for the person. 6. Describe how nurses' involvement in health-promotion can improve the health status of the population. 7. Participate in health-promotion activities with individuals and small groups.
Element 4. To consider various professional situations from ethical point of view. **Performance Criteria** 2.1 Identification of the ethical dimensions of the professional situation. 2.2 Demonstrate of openness and respect for points of view stated. 2.3 Appropriate contribution to discussions. 2.4 Clear differentiation between ethical problems applicable to his/her area of responsibility and those of other professionals. 2.5 Correct implementation of a process for ethical decision-making.	**To consider various professional situations from an ethical point of view, the student will:** 1. Define the issues of ethical violation, ethical dilemmas and ethical distress in an ethical situation. 2. Identify factors that influence moral reasoning in an ethical situation. 3. Identify ethical principles underlying moral reasoning. 4. Identify the moral concepts and principles in an ethical situation. 5. Explore one's own moral-ethical viewpoint in an ethical situation. 6. Describe central ethical issues for nurses. 7. Describe stimuli affecting the nurses' ethical behaviour in their professional roles. 8. Describe the means to ethical nursing practice. 9. Recognize and describe a model of ethical decision-making using ethical analysis (the Murphy and Murphy model of ethical analysis). 10. Describe client participation in decision-making related to ethical issues. 11. For a simulated ethical dilemma and for an ethical dilemma from their own clinical experience, identify: • What information is needed • The ethical issue • The key people and their moral positions • The client's rights • The nurse's rights • Who should make the decision and how • The possible choices the nurses can make • The sections of the Codes of Ethics that could guide the situation. • The legal concepts relevant to the ethical issue 12. Evaluate their own and other students' abilities to analyze an ethical situation based on skills utilized in ethical problem solving and adherence to ethical analysis steps. 13. Describe the collaborative role of the health team in making ethical decisions. 14. Describe the influence of societal values and advanced medical technology on ethical issues. 15. Describe the conditions that override the ethical obligation of health professionals to give treatment.

Element 5. To become involved in maintaining and improving the quality of nursing care. **Performance Criteria** 5.1 Strict use of standards for quality nursing care. 5.2 Identification of nursing care situations requiring improvement. 5.3 Demonstration of interest in the development of the discipline and innovative approaches to nursing. 5.4 Readiness to share knowledge. 5.5 Search for ways to improve the quality of one's own professional actions.	To become involved in maintaining and improving the quality of nursing care, the student will: 1. Follow the standards for nursing care stipulated by institutional policy and the OIIQ. 2. Recognize situations in which those standards are not upheld. 3. Describe possible approaches that could result in improved nursing care for such situations. 4. Describe the role of nursing research in the development of nursing. 5. Be familiar with nursing research taking place in the current practice institution. 6. Actively participate in problem-solving discussions with peers and other health professionals. 7. Consult expert members of the profession in order to improve and enlarge one's knowledge of nursing care. 8. Engage in on-going self-evaluation of strengths, weaknesses and areas to be improved. 9. Plan, implement and evaluate methods used to improve own nursing practice.

APPENDIX E

VANIER COLLEGE NURSING CURICULUM 180.01-96

PROGRAM OBJECTIVES

MEQ PROGRAM OBJECTIVES

FOR

VANIER COLLEGE NURSING 180.01-96

Upon completion of the program, the graduate will:

1. Apply knowledge of nursing as well as the knowledge of the relevant sciences and humanities.
2. Demonstrate the use of the nursing process using the *Roy model of adaptation.*
3. Generate a written nursing care plan for client(s).
4. Use communication as a tool within the nursing process.
5. Plan, implement and evaluate a health teaching plan for client(s) and family.
6. Maintain a therapeutic nurse-client relationship.
7. Demonstrate effective organisational skills in caring for client(s).
8. Demonstrate competency in psychomotor skills.
9. Practice nursing in collaboration with the multidisciplinary health team.
10. Analyse ethical issues encountered in nursing with a view to determining an appropriate course of action.
11. Demonstrate a social awareness of health-related issues in the community.
12. Practice nursing within the legal parameters of the nursing profession.
13. Practice nursing, utilising a set of values that are compatible with those articulated by the nursing profession.

APPENDIX F

VOCABULARLY USED

HEALTH: NURSING: PROGRAM OF STUDY 180.A0

Vocabulary Used

Program

An integrated set of learning activities leading to the achievement of educational objectives based on set standards (*College Education Regulations*, section 1).

Competency

For the specific program component of a technical program: an integrated set of cognitive and psychomotor skills and socio-affective behaviors that enable a student to exercise a role or function, perform a task or carry out an activity at entry level on the job market (*Cadre technique d'élaboration de la partie ministérielle des programmes d'études techniques*, p.3).

Objective

The competency, skills or knowledge to be acquired or mastered (*College Education Regulations*, section 1).

Statement of the competency

For the specific program component of a technical program, the statement of the competency is the result of an analysis of the work situation, the general goals of technical education and, in certain cases, other factors. It consists of an action verb and an object. It must be clear and unequivocal.

For the general education component, the statement of the competency is the result of an analysis of the needs of general education.

Elements of the competency

For the specific program of a technical program, the elements of the competency include only what is necessary in order to understand the competency. They specify the major steps in exercising the competency or the essential elements of the competency.

Foe the general education component, the elements of the objective, formulated in terms of a competency, specify the essential elements of the competency. They include only what is necessary in order to understand and attain the competency.

Standard

The level of performance at which an objective is considered to be achieved (*College Education Regulations*, section 1).

Achievement context

Foe the specific program component of a technical program, the achievement context corresponds to the situation in which the competency is exercised at entry level on the job market. The achievement context does not specify the context for learning or evaluation.

Performance criteria

For the specific program component of a technical program, the performance criteria define the requirements that make it possible to judge the attainment of each of the elements of the competency and consequently of the competency itself. The performance criteria are based on the requirements at entry level on the job market. The performance criteria are not the evaluation instrument but, rather, they serve as a reference for the development of the evaluation instrument. Each element of the competency requires at least one performance criterion.

For the general education component, the performance criteria define the requirements for recognition of the attainment of the standard. All the criteria must be respected for the objective to be attained.

Learning activities

For the specific program component of a technical program, the learning activities are classes (labs, workshops, seminars, practicums or other educational activities) designed to ensure the attainment of the targeted objectives and standards. Colleges are entirely responsible for defining the learning activities and applying the program-based approach.

For the general education component, the elements of the learning activities that may be determined in whole or in part by the Minister are the field of study, the discipline(s), the weightings, the total hours of instruction, the number of credits and any details deemed essential.

(Gouvernement du Québec, Ministère de l'Éducation, 2001, p. 3-4)

APPENDIX G

GLOSSARY OT TERMS

VANIER COLLEGE NURSING CURRICULUM 180.A0

Achievement Context

For the specific program component of a technical program, the achievement context corresponds to the situation in which the competency is exercised at entry level on the job market. The achievement context does not specify the context for learning or evaluation.

Competency

For the specific program component of a technical program: an integrated set of cognitive and psychomotor abilities and socio-affective behaviours that enable a student to exercise a role or function, perform a task or carry out an activity at entry level on the job market *(Cadre technique d'elaboration de la partie ministerielle des programmes d'etudes techniques, p.3).*

Course Number

A six digit, two letter code corresponding to each course. The first three digits represent the departmental code, the fourth digit the semester and the next two digits the assigned course number starting with 01 ... The two letters represent the college code as assigned by the MEQ, with Vanier College being VA.

Course Title

The title given to each course by the faculty. For each specific course, the titles were chose by the department that offers the course and was designed to reflect course content.

Credits

Credits are derived from the ponderation. The hours for theory, laboratory, clinical and homework are added together and divided by three to determine the credits assigned for a course.

Elements of the Competency

For the specific program component of a technical program, the elements of the competency include only what is necessary in order to understand the competency. They specify the major steps in exercising the competency or the essential elements of the competency.

For the general education component, the elements of the objective, formulated in terms of a competency, specify the essential elements of the competency. They include only what is necessary in order to understand and attain the competency.

Health

Health is one dimension of a person's life. Health is a state and a process of being and becoming integrated and whole or well. It is a reflection of adaptation, that is, the interaction of the human adaptive system and the environment. Most individuals strive to achieve a maximum state of wellness.

Health Challenges

Health challenges are events or conditions that persons must cope with in order to achieve or maintain a maximum level of wellness. These can be general and developmental in nature, for example, the birth of a child. They can also

be less common and perhaps unexpected, for example, the development of various pathologies such as diabetes or cancer.

Learning Activities

For the specific program component of a technical program, the learning activities are courses (labs, workshops, seminars, practicums or other education activities) designed to ensure the attainment of the targeted objectives and standards. Colleges are entirely responsible for defining the learning activities and applying the program-based approach.

For the general education component, the elements of the learning activities that may be determined in whole or in part by the Minister are the field of study, the disciplines, the weightings, the total hours of instruction, the number of credits and any details deemed essential.

Learning Context

The learning context corresponds to the specific learning environment in which the competency will be addressed in each course. For competencies involving practicums, it also describes the overall expectations for the specific level of practice in each course. For example, "with the assistance of, under the supervision of, or in collaboration with a faculty member or co-assigned nurse".

Learning Outcomes

Learning outcomes for the courses have been prepared by members of the Nursing Faculty at Vanier College. The learning outcomes specify what the student should be able to do by the end of the course. Each performance criteria should be addressed at some point in the program by the learning outcomes. The learning activities will be based on the expected learning outcomes.

Nursing

Nursing is concerned with promoting adaptation for individuals, families and larger groups in the physiological and psychosocial adaptive modes, thus contributing to health, quality of life, and dying with dignity. Nursing approaches involve assessment of the behaviours reflecting the level of adaptation and the stimuli affecting adaptation, as well as interventions to promote adaptive abilities and enhance environment interactions. As both the family and the community constitute part of those stimuli, nursing is involved with people within the context of their family and community.

Objective

The competency, ability or knowledge to be acquired or mastered *(College Education Regulations,* section 1).

Performance Criteria

For the specific program component of a technical program, the performance criteria define the requirements that make it possible to judge the attainment of each of the elements of the competency and, consequently, the competency itself. The performance criteria are based on the requirements at entry level on the job market. The performance criteria are not the evaluation instrument but, rather, they serve as a reference for the development of the evaluation instrument. Each element of the competency requires at least one performance criterion.

For the general education component, the performance criteria define the requirements for identification of the attainment of the standard. All the criteria must be met for the objective to be attained.

Person
The person, both individually and in family or community groups, is viewed as a unique adaptive system that interacts with constantly changing stimuli from the external and internal environments in order to grow and develop. The terms "Person" and "Client" appear interchangeably throughout this document.

Ponderation
A ponderation is the number of hours assigned by Vanier College for theory, laboratory, clinical and homework per week for each course. The total number of weeks per semester is 15.

Prerequisites
Prerequisites are the courses that a student must have passed before starting the present course. All prerequisites are absolute, that is, the student must pass the prerequisite course(s) before beginning the given course.

Program

An integrated set of learning activities leading to the achievement of educational objectives based on set standards *(College Education Regulations, section* 1).

Standard

The level of performance at which an objective is considered to be achieved *(College Education Regulations, section* 1).

Statement of the Competency

For the specific program component of a technical program, the statement of the competency is the result of an analysis of the work situation, the general goals of technical education and, in certain cases, other factors. It consists of an action verb and an object. It must be clear and unequivocal.

For the general education component, the statement of the competency is the result of an analysis of the needs of general education.