CHAPTER 4

RESULTS AND DISCUSSION

4.1 Results

This descriptive study was designed to describe ethics education for nursing students in Diploma III programs in Central Java regarding students' characteristics, teachers' background, nursing ethics course contents, teaching learning methods and evaluation, and ethical decision making of students. In this chapter, the study results are presented as follows:

4.1.1 Students' characteristics and teachers' background

4.1.2 Ethics course contents

4.1.3 Teaching-learning methods

4.1.4 Evaluation of ethics teaching

4.1.5 Students participation on ethical decision making

4.1.1 Students' Characteristics and Teachers' Background

Two hundred fifty nursing students were approached to participate in this study. Fifty nursing students were taken from each DIII nursing program. Informed consent was given to the students in the covering letter. At the end of the data collection period, there were only two students who did not return the questionnaire (99% response rate). A questionnaire was excluded because of incompleteness. Finally, 247 nursing students were included in this study.

Table 1 shows the personal characteristics of nursing students. The age of the subjects ranged from 19 years to 25 years (mean = 21.25, SD = 1.21). About three fourth of students were female (74.1%). Most of nursing students were Muslim (97.2%), only 1.6% and 1.2% were Protestant Christians and Catholic Christians respectively. Fifty students (20.2%) were from each program except Purwokerto, from which there were only 47 students (19%).

Table 1

Mean, standard deviation, frequencies, and percentages of nursing students' characteristics (n = 247)

Characteristics	Mean	SD	Frequency	Percentage
1. Age				
Range 19 – 25 years	21.25	1.21		
2. Gender:				
Female			183	74.1
Male			64	25.9
3. Religion:				
Muslim			240	97.2
Protestant Christians			4	1.6
Catholic Christians			3	1.2
4. DIII program in nursing				
Blora			50	20.2
Magelang			50	20.2
Pekalongan			50	20.2
Semarang			50	20.2
Purwokerto			47	19.0

Table 2 shows frequencies, percentages, means, and standard deviations of ethics teachers' background. There were 14 teachers. All of them were nursing teachers in their programs. The age of teacher respondents ranged from 25 years to 54 years (mean = 41.64, SD = 7.98). They were 10 female (71.4%) and four males (28.6%). Eleven ethics teachers were Muslim (78.6%) and three teachers were Protestant Christians (21.4%). All of them were married. Most of them had a bachelor degree. Among those who had a bachelor degree, six (42.9%) had bachelor in nursing. Three out of the 14 had a master degree in nursing and one had a master degree in education management. Only one teacher had a Diploma III degree in nursing.

Teaching experience in nursing programs ranged between 2 and 30 years (mean = 16.86, SD = 7.88). Teaching experience in ethics ranged from one year to 13 years (mean = 5.21, SD = 4.25). Nine out of the 14 teachers had attended training or seminar related to ethics. There were five ethics teachers (27.8%) who had not attended an ethics seminar or training. However, every teacher had taken ethics courses in their education. DIII Program in Nursing of Semarang had four ethics teachers, Magelang and Pekalongan had three ethics teachers in each program, and Purwokerto and Blora had two ethics teachers in each program.

Table 2

Means, standard deviations, frequencies, and percentages of ethics teachers' background (n = 14)

Background	Mean	SD	Frequency	Percentage
1. Age				
Range: 25 – 54 years	41.64	7.98		
2. Gender:				
Female			10	71.4
Male			4	28.6
3. Religion:				
Muslim			11	78.6
Protestant Christians			3	21.4
4. Marital status				
Married			14	100.0
5. Level of education				
DIII in nursing			1	7.1
Bachelor in nursing			6	42.9
Bachelor in community health			3	21.4
Master in nursing			3	21.4
Master in education management			1	7.1
6. Teaching experience				
Range: 2 – 30 years	16.86	7.88		
7. Teaching experience in ethics				
Range: 1 – 13 years	5.21	4.25		
8. Area of expertise				
Medical surgical nursing			4	80.0
Pediatric nursing			4	80.0
Maternity nursing			3	60.0
Community health nursing			3	60.0
9. Training/seminar related to ethics*				
Ethics course			14	100.0
Ethics education			5	27.8
Ethics in nursing			5	27.8
Ethics and law			5	27.8
Ethics in general			3	16.7
None			5	27.8
10. The DIII program of teachers				
Semarang			4	28.6
Magelang			3	21.4
Pekalongan			3	21.4
Blora			2	14.3
Purwokerto			2	14.3

* More than one item can be chosen

4.1.2 Ethics Course Contents

Table 3 shows the frequencies and percentages of ethics contents in theory courses and practicum courses. All five programs had two courses in ethics; (1) 'General Ethics and Etiquette' designed two credits within 36 hours in the Year I Semester 1 and (2) 'Nursing Ethics' designed two credits within 36 hours in the Year I Semester 2.

'General Ethics and Etiquette' course included some ethics contents. The same topics of ethics were taught in all programs. These topics were; (1) definition and relationship between ethics and etiquette, (2) theoretical basis of ethics, (3) the functions of ethics in modern era, (4) morals and religion, (5) morals and law, (6) basic theory of moral development, and (7) basic theory of moral values.

The topics of 'Nursing Ethics' were; (1) basic concepts and principles of ethics, (2) code of ethics for nurses, (3) patient's rights, (4) informed consent, (5) individual and professional values, (6) ethics, morality and religion, (7) ethics, morality and law, (8) ethics in caring for patients, and (9) ethical dilemmas and ethical decision making. These topics mentioned above were taught in all programs.

All DIII programs in this study integrated ethics contents in most practicum courses: Medical-Surgical Nursing Practicum in the Year II Semester 2, Maternity Nursing Practicum in the Year II Semester 2, Pediatric Nursing Practicum in the Year III Semester 1, and Mental Health Nursing Practicum in the Year III Semester 1. Only one program integrated ethics contents into Gerontological Nursing Practicum, in the Year II Semester 2.

Table 3

Frequencies and percentages of the ethics contents in theory courses and practicum courses in DIII programs (n = 5)

Ethics courses / contents	Frequency	Percentage
General Ethics and Etiquette	5	100
1. Study plan: Year I semester 1	5	100
2. Number of credit: 2 , Number of hours: 36		
3. Topic of ethics	5	100
(1) Definition and relationship between ethics and etiquette	5	100
(2) Theoretical basis of ethics	5	100
(3) The functions of ethics in modern era	5	100
(4) Morals and religion	5	100
(5) Morals and law	5	100
(6) Basic theory of moral development	5	100
(7) Basic theory of moral values		
Nursing ethics course	5	100
1. Study plan: Year I semester 2	5	100
2. Number of credit: 2 , Number of hours: 36		
3. Topic of ethics		
(1) Basic concepts and principles of ethics	5	100
(2) Code of ethics for nurses	5	100
(3) Patient' rights	5	100
(4) Informed consent	5	100
(5) Individual and professional values	5	100
(6) Ethics, morality and religion	5	100
(7) Ethics, morality and the law	5	100
(8) Ethics in caring for patients	5	100
(9) Ethical dilemmas and ethical decision making	5	100
Practicum courses		
Practicum courses integrated ethics content		
1. Year II Semester 2: Medical-Surgical Nursing Practicum	5	100
2. Year II Semester 2: Gerontological Nursing Practicum	1	20
3. Year II Semester 2: Maternity Nursing Practicum	5	100
4. Year III Semester 1: Pediatric Nursing Practicum	5	100
5. Year III Semester 1: Mental Health Nursing Practicum	5	100

4.1.3 Teaching Learning Methods

Table 4 shows the frequencies and percentages of ethics teaching-learning methods used in theory courses and practicum courses. In 'Nursing Ethics', all five DIII programs used 'lecture' and 'discussion' as teaching methods in this course. 'PBL' and 'case analysis' were used in four DIII programs (80%). The least used method was 'seminar' (60%). Meanwhile, in 'General Ethics and Etiquette', 'lecture' was used in all DIII programs. Three programs used 'discussions' and 'seminar' (60%) in this course.

In practicum courses, all DIII programs performed clinical conference in practicum courses.

Table 4

Frequencies and percentages of ethics teaching methods in theory courses and practicum course in DIII programs (n = 5)

Variables	Frequency	Percentage
Theory Courses		
1. Nursing Ethics*		
(1) Lecture	5	100
(2) Discussion	5	100
(3) PBL	4	80
(4) Case analysis	4	80
(5) Seminar	3	60
2. General Ethics and Etiquette*		
(1) Lecture	5	100
(2) Discussion	3	60
(3) Seminar	3	60
Practicum Courses*		
(1) Clinical conference	5	100

* More than one item can be chosen

4.1.4 Evaluation of Ethics Teaching

Table 5 presents frequencies and percentages of evaluation in theory and practicum courses. The study revealed that, examination, report, class presentation, discussion, and seminar were the methods of evaluation in theory courses of ethics for both the 'Nursing Ethics' and 'General Ethics and Etiquette' courses.

In 'Nursing Ethics', all programs in this study used examination to evaluate the ethics teaching of nursing students. Four out of five programs used discussion and class presentation to evaluate students (80%). Report and seminar were employed by three programs (60%). In 'General Ethics and Etiquette', all programs also used examination to evaluate students. Report and class presentation were used in two programs (40%). Discussion and seminar were used in one program (20%).

In practicum courses, all DIII programs conducted observation of ethical behaviors (100%) of nursing students. Instructors and staff nurses were the persons who were involved in evaluating ethical behaviors in all five DIII programs. Two out of five DIII programs allowed students to evaluate themselves.

Table 5

Frequencies and percentages of evaluation in theory courses and practicum courses in DIII programs (n = 5)

Variables	Frequency	Percentages
Theory courses		
1. Nursing Ethics		
(1) Examination	5	100
(2) Discussion	4	80

Table 5 (Continued)

Variables	Frequency	Percentages
(3) Class presentation	4	80
(4) Report	3	60
(5) Seminar	3	60
2. General Ethics and Etiquette		
(1) Examination	5	100
(2) Report	2	40
(3) Class presentation	2	40
(4) Discussion	1	20
(5) Seminar	1	20
Practicum courses		
1. Evaluation of ethics teaching		
(1) Observation of ethical behaviors	5	100
2. Evaluation form for ethical behaviors	5	100
3. The persons involved in evaluating ethical behaviors		
(1) Instructors	5	100
(2) Staff nurses	5	100
(3) Student's self assessment	2	40

4.1.5 Students Participation on Ethical Decision Making

Table 6 shows means, standard deviations, and frequencies of students' participation on ethical decision-making. The ethical decision-making based on the patient-centered model (mean = 2.09, SD = .51) and the bureaucratic-centered model (mean = 2.02, SD = .54) had higher mean scores than those based on the physician-centered model (mean = 1.68, SD = .57). In addition, the frequency of decision based on patient-centered and bureaucratic-centered models were at a high frequency on the physician-centered model was at a moderate frequency.

Table 6

Means, standard deviations, and frequencies of students' participation on ethical decision making in DIII programs (n = 247)

Ethical decision making	Mean	SD	Frequency
1. Patient-centered model	2.09	.51	High
2. Bureaucratic-centered model	2.02	.54	High
3. Physician-centered model	1.68	.57	Moderate

Table 7 shows means, standard deviations, and frequencies of ethical decision-making based on the patient-centered model. From items listed, six items were at high frequencies and three items were at moderate frequencies.

The six items with high frequency were; (1) provide more information when patient makes decision without adequate information (mean = 2.51, SD = .55), (2) provide opportunity for family to be involved in decision making when patient is incompetent (mean = 2.49, SD = .55), (3) help patient who is ignored by colleagues (mean = 2.44, SD = .60), (4) never avoid caring for patient even though there is a risk to contract infection from patient (mean = 2.19, SD = .60), (5) strictly maintain patient confidentiality as requested even though patient's spouse keeps asking (mean = 2.13, SD = .79), and (6) speak with team leader on behalf of patient when patient does not receive care based on his/her rights (mean = 2.03, SD = .78).

The lowest mean score of ethical decision making based on the patient-centered model was 'support patient/family to make decision based on their needs

even though health team does not agree with the decision' (mean = 1.56, SD = .87). However, this item was within the range of moderate frequency.

Table 7

Means, standard deviations, and frequencies of ethical decision making based on the patient-centered model (n = 287)

Patient-Centered Model	Mean	SD	Frequency
1. Provide more information when patient makes decision without adequate information	2.51	.55	High
2. Provide opportunity for family to be involved in decision making when patient is incompetent	2.49	.55	High
3. Help patient who is ignored by colleagues	2.44	.60	High
4. Never avoid caring for patient even though there is a risk to contract infection from patient	2.19	.60	High
5. Speak with team leader on behalf of patient when patient does not receive care based on his/her rights	2.13	.79	High
6. Speak with team leader on behalf of patient when patient does not receive care based on his/her rights	2.03	.78	High
7. Ask physician on behalf of patient when patient has questions about treatment plan	1.81	.81	Moderate
8. Consult physician about treatment plan when the plan does not support patient's values/beliefs.	1.70	.88	Moderate
9. Support patient/family to make decision based on their needs even though health team does not agree with the decision	1.56	.87	Moderate

Table 8 shows means, standard deviations, and frequencies of ethical decision-making based on the bureaucratic-centered model. The results of this study

revealed that four out of eight items of ethical decision-making based on the bureaucratic-centered model were at high frequencies and the other four items were at moderate frequencies. The four items with high frequencies were: (1) consult with team leader/instructor before providing any advice to patient (mean = 2.47, SD = .62), (2) report to the team leader immediately about any problems (mean = 2.45, SD = .61), (3) maintain the confidentiality of colleagues to protect institution's image (mean = 2.23, SD = .65), and (4) report to the team leader when patient's rights are violated (mean = 2.09, SD = .75).

The lowest mean score of ethical decision making based on the bureaucratic-centered model was 'report to the team leader when colleagues avoid caring for patient' (mean = 1.52, SD = .92), but it was at a moderate frequency.

Table 8

Means, standard deviations, and frequencies of ethical decision making based on the bureaucratic-centered model (n = 247).

Bureaucratic-centered model	Mean	SD	Frequency
1. Consult with team leader/instructor before providing any advice to patient	2.47	.62	High
2. Report to the team leader immediately about any problems	2.45	.61	High
3. Maintain the confidentiality of colleagues to protect the institution's image	2.23	.65	High
4. Report to the team leader when patient's rights are violated	2.09	.75	High

Table 8 (Continued)

Bureaucratic-centered model	Mean	SD	Frequency
5. Strictly comply with institution's regulations even though they may not benefit patient	1.96	.81	Moderate
6. Follow every assigned duty without questions	1.91	.69	Moderate
7. Follow orders of higher authorities without any questions	1.59	.82	Moderate
8. Report to the team leader when colleagues avoid caring for patient	1.52	.92	Moderate

Table 9 shows means, standard deviations, and frequencies of ethical decision-making based on the physician-centered model. There was only one item of ethical decision-making based on physician-centered model reported at high frequency, that was 'advice patient to ask the physician when patient asks about his/her illness' (mean = 2.19, SD = .88).

The other seven items of ethical decision-making based on physician-centered model listed were at moderate frequencies. Two items with the second highest frequencies were 'refer to physician's order when patient does not comply with treatment plan' (mean = 1.93, SD = .72) and 'advice patient to ask the physician when patient asks about prescribed medicine' (mean = 1.89, SD = .71). However, the mean scores of these items were within a moderate level.

The lowest mean score was on the item 'avoid answering patient's questions because afraid that physician may change treatment plan' (mean = 1.24, SD = .90). However, it was at a moderate frequency.

Table 9

Means, standard deviations and frequencies of ethical decision making based on the physician-centered model (n = 247)

Physician-centered model	Mean	SD	Frequency
1. Advice patient to ask the physician when patient asks about his/her illness	2.19	.88	High
2. Refer to physician's order when patient does not comply with treatment plan	1.93	.72	Moderate
3. Advice patient to ask the physician when patient asks about prescribed medicine	1.89	.71	Moderate
4. Report to the physician when patient does not comply with the treatment	1.81	.95	Moderate
5. Explain to the patient/family on behalf of physician when they are unsatisfied with physician	1.61	.90	Moderate
6. Follow physician's treatment plan even though the plan does not respond to patient's needs	1.48	.95	Moderate
7. Do not respond to any questions of patient about treatment plan to avoid conflicts with physician	1.27	.89	Moderate
8. Avoid answering patient's questions because afraid that physician may change treatment plan	1.24	.90	Moderate

4.2 Discussion

The discussion on this study is presented in three main parts:

4.2.1 Students' Characteristics and Teachers' Background

4.2.2 Ethics Teaching in D III Programs in Nursing

4.2.3 Students Participation on Ethical Decision Making

4.2.1 Students' Characteristics and Teachers' Background

4.2.1.1 Students' characteristics

Nursing students in this study varied in age, from 19 to 25 years (mean = 21.25, SD = 1.21), which is the age range of students in regular class of DIII programs in Indonesia. A regular class is a class that admits students from senior high schools and students who are less than 26 years old (Nursing Academy, 1997).

The majority of students in this study were female (74.1%). The higher proportion of female students is congruent with the literature review of Burkhardt & Nathaniel (2002), which mentioned that in every culture, women have been healers. Because nursing is primarily a profession of women, the status of women in society has been an important factor-determining role of nurses in the heath care system.

Most nursing students in this study were Muslim (97.2%). Indonesia, the world' largest Muslim country, approximately 90% of the population are Muslim (Shields & Hartati, 2003). Therefore, the sample in this study represents nursing students and people in Indonesia in terms of religion.

4.2.1.2 Teachers' background

Majority of the ethics teachers in the DIII programs in nursing, Health Polytechnic Semarang were female (female =10, male = 4). Shields and Hartati (2003) reported that the overall ratio of female to male nurses in Indonesia is about 4:1, and hence the ratio in the ethics teachers in this study.

The five DIII programs in nursing had 14 ethics teachers. All of them were lecturers in their nursing program. This finding is supported by a similar study of Suttharangsee et al. (2004) on 'Ethics education in nursing education institutes in

Thailand', which found that most lecturers were nurse lecturers. Ketefian (1999) reported that many schools leave teaching of ethics to all faculties, with the idea that all must assume responsibility for nursing and addressing relevant ethical concerns appropriate to different areas of practice. However, the study of Suttharangsee et al. (2004) also found that the students suggested faculty to invite ethics teachers from other disciplines, in order to gain other points of view in ethics.

In this present study, most of them received at least bachelor degrees (92.9%). Among those who had a bachelor degree, six had bachelor in nursing. In addition, four teachers had master degree. Teachers' experiences in ethics ranged from one year to 13 years. The majority of teachers had attended training or a seminar related to ethics, such as ethics education, ethics in nursing, ethics and law, and ethics in general. Nine out of the 14 had attended training or seminar in ethics. Therefore, the qualifications of teachers were adequate to provide ethics courses in Diploma III programs.

However, this study also found that one teacher earned DIII program in nursing and five out of fourteen ethics teachers had never attended training or a seminar in ethics. This condition may indicate that some ethics teachers are not qualified, since the study of Adachi, Miyabayashi, and Miyawaki (2002) suggested that a seminar on nursing ethics provided opportunities for nurses to review his or her practice, to look back on their own nursing and think about what ethical problems are. Additionally, Shields and Hartati (2003) reported that a major problem faced by the Indonesian government is the low level of basic education in nursing. Nurses with diplomas and degrees are needed to teach, and often take up teaching

position immediately after graduation, with little clinical practice to consolidate their education available.

Teacher characteristics are one of the most important factors that contributing to teaching ethics (Dinç & Görgülü, 2002). Thompson and Thompson (1989) proposed that the persons who teach ethics in nursing should be experienced educators who can adopt ethics method to the contents. They also should have expertise in ethics as well as in nursing and the ability to share that expertise in a meaningful and understanding manner. They should be able to create a trusting learning environment.

4.2.2 Ethics Teaching in D III Programs in Nursing

4.2.2.1 Types of ethics courses

All five DIII programs in this study had a specific course in nursing ethics, entitled 'Nursing Ethics'. Nursing Ethics was a two-credit course with 36 hours in the second semester of the first year. In addition to 'Nursing Ethics', there was another course of ethics, entitled 'General Ethics and Etiquette'. Besides that, all DIII programs integrated ethics contents in most practicum courses including Medical-Surgical Nursing Practicum, Maternity Nursing Practicum, Pediatric Nursing Practicum, Mental Health Nursing Practicum, and Community Health Nursing Practicum. One DIII program was ethics contents integrated into Gerontological Nursing Practicum, because this subject was an elective course in this program.

The results of this study are somewhat supported by a similar study of Suttharangsee et al. (2004) which found that 12 nursing institutions in Thailand

included ethics in philosophy in their curriculum, five out of 12 nursing institutions integrated ethics course in other theory courses, and every curriculum had integrated ethics content into their practicum courses. In the contrary, Petrozolla (2002) reported that, the most common strategy in the state of Florida is integration throughout the curriculum. Placement of an ethics focus within courses varies from the first to the last courses. However, Ericksen (1993) reported that the integrated approach requires tracking the curriculum to ensure that all contents are covered.

All programs in this study had a specific course in nursing ethics, which are essential for nursing students. Gaul (1987) mentioned that nursing students are at a transitional period for moral development and theoretically are extremely vulnerable to change. Therefore, completion of a structured course in nursing ethics should enable them to reason about moral choices in a logical principled manner when making the decision. Similarly, Nolan and Smith (1995) found that the majority of students consider the teaching of ethics were important. They wanted a course that is practically based in which will help nursing students cope with situations likely to be encountered in their professional practice. Moreover, Gaul (1989) mentioned that a specific course in nursing ethics provides students with the necessity instruction, time, and experience to acquire a working knowledge of ethical theory and models in nursing. Gaul (1987) found that students who exposed to the ethics course might achieve a higher level of moral development than the control group, thus accounting for the positive correlation between moral choice and moral action. In addition, the study revealed that students who were enrolled in the ethics course had higher mean scores on ethical choice and ethical action. This study lends support to the inclusion

of a course in ethics in nursing curricula. In fact, an ethics course increased the students' ability to make and to indicate that they would act upon, the ethically correct decision. Then, a strong cause for an independent course in nursing ethics has been made.

In brief, it was apparent that faculties had chosen a variety of approaches to incorporate ethics content into their curriculum. In Health Polytechnics Semarang, the combination of having specific courses and integrating these courses into other theory or practicum courses in all DIII programs in nursing were employed.

4.2.2.2 Ethics course contents

With reference to Table 3, all programs had two courses of ethics; 'General Ethics and Etiquette' and 'Nursing Ethics'. In all programs, 'General Ethics and Etiquette' included some ethics contents, which are the same in all programs. They were; definition and relationship between ethics and etiquette, theoretical basis of ethics, the functions of ethics in modern era, morals and religion, morals and law, basic theory of moral development, and basic theory of moral values.

The topics of 'Nursing Ethics' were; basic concepts and principles of ethics, code of ethics for nurses, patient' rights, informed consents, individual and professional values, ethics, morality and religion, ethics, morality and the law, ethics in caring for patients, and ethical dilemmas and ethical decision making. Those topics mentioned above were taught in all five DIII programs in nursing.

The teaching of ethics seems to be overlapping. Therefore, in the year of 2004 the Sister School Project and Health Polytechnic Semarang are planning to implement curriculum reform (Health Polytechnic Semarang, 2004). In the

curriculum reform it is proposed to make changes to the Diploma III National Nursing Curriculum. 'General Ethics and Etiquette' is planned to be deleted. The contents of the 'General Ethics and Etiquette' that was previously repeated will be incorporated into a new course 'General and Nursing Ethics' which is designed for two credits and is proposed for the second semester of the first academic year. The course will provide the students with an understanding of the general principles of ethics based on the values, morality, norms, and rights of the general principles of human being as a foundation to shape professional nursing behaviors and attitudes. In this course, case studies and group learning activities will challenge students to examine ethical issues and dilemmas as they apply to nursing profession. Students will apply ethical principles within a framework of accountability of the individual person and nurse to the community, nursing profession, and within the context of collaboration with other health professionals. Assessment tasks will provide opportunities for students to consolidate knowledge of general principles and explore areas of interest in significant detail (Health Polytechnic Semarang, 2004).

The ethics course contents reported in this study support the goal of ethics teaching at undergraduate level. It is aimed to prepare general nurses who provide care in various settings. Therefore, the ethics contents should address the philosophical and professional foundations of ethics to include the following: recognize relevant ethical theories and principles, develop skill in decision making, bringing to bear critical thinking skill, develop an understanding of the nature of rights, responsibilities, obligation and how they operate within social and health care (Ketefian, 1999). Gaul (1989) also proposed that in addition to ethical theories,

nursing students should be exposed to various theoretical approaches regarding moral reasoning so that they can understand better the ethical decision-making and the factors influencing ethical decision making in nursing practice.

The findings of this study are somewhat supported by study of Dinç and Gö rgülü (2002) on 'Teaching ethics in nursing'. This study examined nursing students' views toward the content of nursing ethics; definition of ethical concepts and principles, explanation of basic theories of ethics, ethical problems and dilemmas in nursing practice, rights and the ICN code of ethics for nurses, legal issues in Turkey, and case study discussion. Nursing students stated that the discussion of case study analysis using ethical principles, the topics of patients' rights, and ICN code were very useful in developing ethical decision-making skills.

Gaul (1987) found that an understanding of ethical principles and theories as well as the application of them to the role of professional nurse was essential to ethical decision-making. Seventy-four percent of recent graduates stated that the ethical content in their nursing program most influenced their ethical decision making skills, yet only 23% used an ethical model framework in analyzing and resolving the ethical dilemma in practice.

In addition, by discussing the differences between the development of codes of ethics for the practice of medicine and the practice of nursing, important distinctions usually give the student nurse a greater respect for, and understanding of, the values of both medicine and nursing. This respect and understanding are essential to the effective collaboration of nurses, physicians and other health professionals (Fry, 1989; 1994). Teaching ethics by focusing on ethical concepts

provides students the opportunity to test their understanding by analyzing and discussing carefully in making the right decision.

In summing up, ethics education has great value in helping nursing students make decisions ethically in practice. Nursing teachers should think carefully and critically about the content of the nursing ethics course. In order to enhance ethical decision making skills of nursing students, the major ethics content should be put into the nursing curriculum including ethical theories, ethical principles, professional code of ethics, and patients' rights.

4.2.2.3 Teaching-learning methods

All five D III programs in this study used lecture and discussion as methods in 'Nursing Ethics'. 'PBL' and 'case analysis' were used in four programs. The least used method was 'seminar'. Whereas, in 'General Ethics and Etiquette', all programs used 'lecture', followed by 'discussions' and 'seminar'. This finding is similar to result of a previous study of Suttharangsee et al. (2004), which found that lecture, discussion, and situation analysis were mostly used as teaching methods. PBL, seminar, and role-play were rarely used in ethics teaching in Thailand.

This present study showed that 'lecture' was employed both in 'Nursing Ethics' and 'General Ethics and Etiquette' in all programs. Bevis and Murray (1990) mentioned that a lecture can cover a large amount of content in a short time and is suitable for almost any group size. However, the disadvantages of lecture are numerous. There is a little or no proof that any learning is taking place. Students are largely passive and there is a little participation. Furthermore, lecturing is somewhat inappropriate in theoretical-practical subjects, such as nursing discipline.

Even though the lecture has some weakness, it is still necessary for ethics teaching, because ethics knowledge is generally abstract and complex, and involves conflicting concepts. It is difficult to make nursing students understand ethics especially at undergraduate level, when the students do not have background knowledge in ethics. The study of Daodee (2002) in a nursing college in Thailand also found that the frequency of lectures in every course fell into 'almost always' and 'often'. Similarly, a study of Cowman (1995) on teaching-learning preferences among student nurses, found that lectures received a very high preference rating from all groups of nursing students. Rowles and Brigham (1998) mentioned that the use of lecture is to clarify complex, confusing, or conflicting concepts. Lecture can be used to provide and cover background information from scattered sources. Lectures use time efficiently to cover complex material. Similarly, Quinn (1995) mentioned that a lecture was being commonly used in teaching learning because the speed of delivery can be closely related to the level of difficulty of the subjects.

Considering the uses and disadvantages of lecture, lectures should be used in combination with other methods such as discussion or case analysis. Ulrich (1999) stated that one of the challenges in nursing ethics education is to find effective means to convey the difficult and abstract concept of moral philosophy to a group of learners who may have little or no previous exposure to such material.

The results of this study showed that 'discussion' was used both in 'Nursing Ethics' in five programs, and in 'General Ethics and Etiquette' in three programs. Van-Hoozer (1987) mentioned that the advantages of discussion include immediate feedback and reinforcement, flexible sequencing of information, and branched

organization of information. However, lack of participation by some learners may occur. In addition, Daodee (2002) said that the case study and discussion methods fit together, like hand and glove. Discussion is useful in ethics teaching because it may lead students through the process of analyzing. A study of Dinç and Görgülü (2002) on 'Teaching ethics in nursing' used the discussion method in a case study. It was found that although the case study discussions were adequate, students still recommended an increase in the amount of classroom discussion.

In this present study, it was found that four nursing programs used case analysis in teaching 'Nursing Ethics'. Case analysis helps students analyze the nature of the ethical problems in this situation and distinguish the moral values from the nonmoral values involved. This method emphasizes the role of nurses in ethical decision-making. It is an excellent approach to be used for students in their initial exposure to the clinical setting because it sensitizes students to how nurses function in clinical situations (Fry and Johnstone, 2002). Gaul (1989) reported that case analysis would stimulate a desire to acquire knowledge based on perceived need. The study of ethics requires a tolerance for ambiguity, an awareness, and appreciation for the position of others. Repeated exposure of students to opposing positions should increase their tolerance for ambiguity that will accompany ethical decision making in nursing practice. Various types of teaching and learning strategies can be effectively employed to assist students' professional development in ethical decision-making; however, it is evident that case analysis has been shown to be an effective method of teaching ethics (Cessells & Redman, 1989; Dinç and Görgülü, 2002; Fry, 1994; Gaul 1989; Thompson & Thompson, 1989).

The result of this study revealed that all programs performed clinical conference in practicum courses. Clinical conference provided many opportunities for students to participate and to learn from other students and faculty (Rossignol, 2000). Rossignol also (2000) reported that a standard and expected component of nursing practice is the clinical conference. It was found that faculty used a student-centered model to structure conferences and encourage students' verbal participation. Clinical conferences also emphasize the critical importance of the faculty role in monitoring and challenging students thinking. Teachers are urged to promote critical thinking in clinical conference techniques by asking high cognitive questions that require students to interpret, explain, infer, or justify one's opinions.

4.2.2.4 Evaluation of ethics teaching

With reference to Table 5 the study revealed that examination, report, class presentation, discussion, and seminar were used to evaluate students' competencies in ethics in theory courses for both 'General Ethics and Etiquette' and 'Nursing Ethics'. All D III programs in nursing used examination, in the form of multiple-choice test. Most institutions used discussion and class presentation. This result of this study is almost the same as that of the study of Suttharangsee et al. (2004) which found that most nursing institutes in Thailand evaluated theory course in ethics teaching by multiple-choice test, followed by report and participation in discussion. Dinç and Görgülü (2002) also found that in ethics course, multiple-choice tests were suggested by nursing students to be more useful and easier for students to respond to.

In practicum courses, the findings of this study revealed that all programs conducted observation of ethical behaviors. The evaluation involved instructors, nurses at the wards, and student's self-assessment. In all five programs, instructors and staff nurses evaluated the ethical behaviors of students. The results of this study are somewhat supported by a study of Suttharangsee et al. (2004), which found that observation for students' ethical behaviors was mostly used in evaluating in clinical practice. Evaluators included lecturers, nursing students, and nurses.

However, Sofear (1995) mentioned that the application of the learning in the clinical setting is less easy to evaluate. Evaluators included nursing lectures, nursing students and nurses. Furthermore, Thompson and Thompson (1989) suggested that in the clinical setting, the learners' approach to client care, co-workers and faculty could be evaluated in terms of ethical behaviours.

4.2.3 Students Participation on Ethical Decision Making

Referring to Table 6, nursing students demonstrated that they had more participations in ethical decision making based on the patient-centered model (mean = 2.09, SD = .51) and bureaucratic-centered model (mean = 2.02, SD = .54) than on the physician-centered model (mean = 1.68, SD = .57). The results of this study are similar to previous findings that nursing students participated more frequently in ethical decision-making based on the patient-centered model than on bureaucratic-centered model and the physician-centered model (Chaowalit et al., 2004).

However, a study of Swider, McElmury, and Yarling (1985) revealed that nursing students made ethical decisions based on the patient-centered model less than on the physician-centered model and bureaucratic-centered model. Their study

indicated that a majority of the first responses from senior baccalaureate nursing students were in the bureaucratic-centered category. The finding demonstrated that nursing students first sought to work within the system. Students reflected an orientation to seek assistance from professional groups in resolving ethical dilemmas. The researchers concluded that examining the decision-making by nurses is important in arriving at a better understanding of the relationship between ethical problems in professional practice and the influence of social organizations or bureaucracies on the nursing rule. In addition, Treacy (1989. cited by Maclean, 1997) stated the hierarchical structures of the clinical areas have been replicated in nursing education, with students expected to accept unquestioningly information as transmitted to be passive learners.

Nursing students in this study made decisions based on patient-centered model more frequently than on bureaucratic and physician-centered models because they contacted with patients more frequently than with physicians in clinical practice. Therefore, the students may be more frequently involved with decision based on the patient-centered model. Additionally, it could be the items about ethical decision-making based on patient-centered model are more relevant to the scope of students ability. Moreover, nursing curricula are mostly concerned with holistic care and are patient-centered.

4.2.3.1 Ethical decision making based on the patient-centered model

The findings of this study revealed that nursing students participated in ethical decision-making based on patient-centered model at high frequencies (six items) and moderate frequencies (three items).

The items with high frequency were; (1) provide more information when patient makes decision without adequate information, (2) provide opportunity for family to be involved in decision making when patient is incompetent, (3) help patient who is ignored by colleagues, (4) never avoid caring for patient even though there is a risk to contract infection from patient, (5) strictly maintain patient confidentiality as requested even though patient's spouse keeps asking, and (6) speak with team leader on behalf of patient when patient does not receive care based on his/her rights.

The first highest frequency of ethical decision-making based on the patient-centered model was 'providing more information when patient makes decision without adequate information'. This may be because nursing students in this study have already completed theory courses before entering clinical practicum. They have already learned ethical decision-making in their ethics course. Therefore, nursing students in this study may have sufficient competency to provide information in order to assist a patient in making a decision. Moreover, hospitals in Indonesia require written informed consent from patients, which protects patents' rights and nurses' actions. To complete this requirement, all patients must be informed clearly regarding possible outcomes, alternatives, and risk of treatments, and are required to give their consent freely, in order to assure legal protection of patients' right to personal autonomy (Beauchamp & Childress, 2001).

The study revealed that 'providing opportunity for family to be involved in decision making when patient is incompetent' had the second highest frequency of ethical decision-making based on the patient-centered model. This finding was

somewhat supported by a study of Rr-Pujiastuti (2004), which found that the close relationship among families and relatives for sharing information builds a trusting relationship among patients, families, and health care providers to know any situation of the patient. Furthermore, Koentjaraningrat (1985) reported that in Indonesian culture, especially Javanese, the family is very important. The individual serves as a harmonious part of the family. Life in society should be characterized by 'rukun'. 'Rukun' is shooting over of differences, cooperation, mutual acceptance, quietness of heart, and harmonious existence. Mutual assistance and sharing of burdens, within the family, should reflect the concept of 'rukun'. Therefore, even though a patient is competent, the family still has an important role in decision-making. In addition, Riad (1995) mentioned that in Islamic community, the family system is very strong. When a member of Muslim family gets sick, he or she will be surrounded by a younger and more able generation who will take responsibility for him or her. The belief that this is a phase of life that we will all experience, and that each has a responsibility and role to play, highlights the spirit of this love and courtesy. Moreover, the Code of Ethics for Nurses in Indonesia in the part on nurses and clients, clearly mentions that 'in providing nursing care, nurses maintain good atmosphere, with respect to culture value, custom, and religion of the client' (Indonesia Nursing Association, 2002).

Those findings demonstrated that information is important not only because information is very essential for making decisions but also because of legal aspects. Legal problems will appear if a nurse makes decision without family involvement when the patient is incompetent and lacks information. It will cause serious problem,

legal problem and problem about relationship with family. A nurse can be sued by a patient if a problem occurs.

Another situation participated in by students is to 'help patient who is ignored by colleagues'. Acting on this situation reflected that nursing students are taught to be concerned about patients' safety. The students realized when patients were ignored, were at risk of danger or harm, or were in a life-threatening situation. Therefore, health care providers should be concerned about such situations, as the Hippocratic Oath states 'above all, do no harm', which reflects non-maleficence (Fry & Johnstone, 2002). Additionally, in Islamic beliefs, Muslims are responsible to care for life, by keeping themselves as well as others out of danger and by caring for health and fitness (Riad, 1995).

The study of Ketefian (1989) on 'Moral reasoning and ethical practice in nursing' some what supports the results of this study. The study also indicated that nurses used the ethical principles of nonmaleficence and beneficence most frequently. Additionally, all codes of nursing ethics request us to prevent or remove harm. Similarly, the Indonesian Nurses Association (2000) Code of Ethics for Nurses in Indonesia states that 'Nurses act to protect clients from incompetent, unethical, or illegal health care conducts by others'.

The fourth highest frequency was 'never avoid caring for patient even though there is a risk to contract infection from the patient'. Nursing students have already completed all coursework requirements before entering clinical practices; they then had enough knowledge and skills in a clinical nursing practicum. The nursing students were able to use the hospitals' equipment effectively. Additionally,

considering the findings of this study that 97.2% nursing students were Muslim, Islam requires that Muslims must do their best to maintain the trust given to them by Allah as he gave them life and they must do their best to maintain life within the limits of knowledge and financial resources (Riad, 1995).

The findings are supported by a study of Kelly (1993), which found that senior undergraduate students experienced guilt when they could not help the patients. They also expressed disappointment. Catalano (1994) mentioned that caring for patients is the primary obligation even though there is a fear of being in danger. Additionally, Burkhardt and Nathaniel (2002) stated that as professional nursing practice, nurses have an obligation to patients above all. Thus, nurses have to give priority to meeting the needs of each patient.

The findings of this study demonstrated that students understood ethical principles and code of ethics for nurses, especially the Code of Ethics for Nurse in Indonesia. Moreover, Beauchamp and Childress (2001) stated that ethical principles are guides to moral decision-making and moral action. Similarly, a study of Han and Ahn (2000) on 'An analysis and evaluation of student nurses' participation in ethical decision making' in Korea supports this study. It was found that nursing students were able to identify ethical dilemmas, apply the Code of Ethics for Korean Nurses, and apply ethical principles as well in their decision-making.

4.2.3.2 Ethical decisions making based on the bureaucratic-centered model

The finding of this study revealed that the ethical decisions based on the bureaucratic-centered model of nursing students were at a high frequency. There were four items with high frequencies; (1) consult with the team leader/instructor

before providing any advice to patient, (2) report to the team leader immediately for any problems, (3) maintain the confidentiality of colleagues to protect institution's image, and (4) report to the team leader when patients' rights are violated.

In this study, nursing students made ethical decisions at high frequency at consultation and reporting to the team leader or instructor. In clinical setting, because nursing systems usually use teamwork, which consists of leader and members, students are usually members of the team, therefore the students need to report to team leader when they are not sure about their competency or to avoid problems due to incompetence.

Chaowalit, Suttharangsee, and Takviriyanan (1999) found that third-year and fourth-year nursing students experienced lack of autonomy and authority in their nursing practice. Therefore, the nursing students needed consultation with the instructors. Similarly, a study of Tabak and Reches (1996) found that 95% of third and fourth year nursing students consulted with their supervisors. The data indicated that the instructor was an important resource person for ethics practicum courses.

The findings of this study revealed that the third highest frequency of ethical decision-making based on the bureaucratic-centered model was 'maintain the confidentiality of colleagues to protect the institution's image'. This finding is supported by a study of Peternelj-Taylor (2003) which reported that when nurses were confronted with an unethical behavior of a colleague (who may also be a friend), nurses frequently experience divided loyalties and believe that they are forced to choose among their relationships with the colleagues, their professional

standard of practice, their responsibility to clients, and their commitment to the employers.

In addition, Burkhardt and Nathaniel (2002) stated that loyalty is a natural product of long-term acquaintance and close working relationships. Nurses work together in close proximity day in day out. No other profession is so intimately connected with the essence of life. Nurses work together closely and identify with each other. This condition may create loyalty. Thus, nurses often avoid being labeled a whistleblower. Nathaniel (2002) mentioned that whistle-blowing may crate chaos within the workplace. McDonald and Ahern (2000) defined whistleblower as one who identifies an incompetent, unethical, or illegal situation in the workplace and report it to someone who may have the power to stop the wrong.

In Indonesia culture, particularly Javanese, the ideal human virtues include avoiding of conflict and understanding of others. The adolescents also introduce the concept of 'sungkan'. 'Sungkan' includes obedience to superiors, which is considered not only a useful quality in social interactions, but it also a way of avoiding conflict an ensuring safety (Koentjaraningrat, 1985). Therefore, nursing students in this study preferred to maintain confidentiality of colleagues to protect the institution's image.

4.2.3.3 Ethical decision making based on physician-centered model

The results of this study revealed that only one out of eight items of the list of ethical decision-making based on the physician-centered model was at a high frequency. That is, 'advice patient to ask the physician when patient asks about his/her illness'. Although the students in this study were third year students, they

still had limited knowledge about diseases. They realized that the medical doctors had more knowledge about diseases. The medical doctors had authority to disclose information about patients' illness. The nursing students also perceived the lack of authority. The study of Kelly (1993) supported the findings of the present study, which examined how senior undergraduates perceived the 'real world' of nurses and in particular, their future as ethical practitioner. It was found that most nursing students perceived themselves as fairly powerless to control the forces that would act on them such as medical staff.

Burkhardt and Nathaniel (2002) mentioned that the traditional nurse was expected to obey the physician. Physicians demanded obedience, and nurses hesitated to disagree with a physician. When there is a conflict between nurses and physicians, the relationship is stressful and damaging to nurses, physicians, and patients alike. When nurses question or disagree with physicians, they may feel distressed, believing they are being disloyal to the physician. Corley (1998) mentioned that nurses are afraid to challenge a physician, who has more power. Nurses are also hesitant to report changes in a patient's condition. Therefore nurses experience ethical distress. In addition, a study of Grunstein-Amadore (1992) also somewhat supported the findings of the present study. Her study found that nurses and physicians acted out of different values. Nurses placed the highest values on the caring perspective, but physicians value above all the patients' rights and the scientific approach. The study suggested that there is a need for development of a new foundation based on common professional attributes of nurses and physicians.

The two other items with second highest frequencies were ‘refer to physician’s order when patient does not comply with treatment plan’ and ‘advice patient to ask the physician when the patient asks about prescribed medicine’. The findings of this study demonstrated that nursing students perceived that those two items mentioned above were not within the scope of their authority. In fact, medical doctors mostly undertake health care system and services in Indonesia. In addition, considered that approximately 90% Indonesia populations are Muslims (Shield & Hartati, 2003), Riad (1995) mentioned that in the Muslim view, treatment decisions are typically discussed among the doctors and family members. The doctors are trusted to have the scientific knowledge. Therefore, nursing students may tend to refer to the medical doctor when a patient asks about the treatment.