Development and Psychometric Evaluation of the Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai)

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Nursing (International Program)

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ชื่อวิทยานิพนธ์ การพัฒนาและการประเมินคุณภาพของแบบประเมินความมุ่งมั่นทางจริยธรรมของนักศึกษาพยาบาลไทย

ผู้เขียน นางชุติมา เพิงใหญ่

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บทคัดย่อ

การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อพัฒนาและประเมินคุณภาพของแบบประเมินความมุ่งมั่นทางจริยธรรมของนักศึกษาพยาบาล โดยมีขั้นตอนการดำเนินงาน 2 ระยะ คือ (1) ระยะการพัฒนาแบบประเมินโดยการสนทนากลุ่มและการทบทวนวรรณกรรมที่เกี่ยวข้อง ได้ข้อคำถามจำนวน 138 ข้อ ซึ่งมีมาตรวัดแบบลิเกิร์ต 5 ระดับ และ (2) ระยะการประเมินคุณภาพของแบบประเมิน โดยผ่านการตรวจสอบความตรงเชิงเนื้อหาจากผู้เชี่ยวชาญจำนวน 5 ท่าน ได้ค่าดัชนีความตรงเนื้อหารายข้อ (I-CVI) เท่ากับ .80-1.0 ความตรงเชิงเนื้อหาทั้งฉบับ (S-CVI/UA) เท่ากับ .90 และความตรงเชิงเนื้อหาทั้งฉบับโดยเฉลี่ย (S-CVI/Ave) เท่ากับ .92 นำแบบประเมินไปทดลองใช้กับนักศึกษาพยาบาลจำนวน 30 คน เพื่อหาความสอดคล้องภายใน ได้ค่าสัมประสิทธิ์แอลฟ่าของครอนบาคเท่ากับ .98

เก็บรวบรวมข้อมูลในนักศึกษาพยาบาลชั้นปีที่ 4 จากมหาวิทยาลัยและวิทยาลัยพยาบาลทั่วประเทศจำนวน 10 แห่ง จำนวน 809 คน ผลการวิเคราะห์องค์ประกอบด้วยวาริแมกซ์ พบว่ามี 6 องค์ประกอบ 81 ข้อคำถาม ดังนี้ (1) เคารพความเป็นส่วนตัวและรักษาข้อมูลที่เป็นความลับของผู้ป่วย (22 ข้อ), (2) ให้ความเคารพผู้ป่วย (25 ข้อ), (3) ดูแลผู้ป่วยแต่ละรายอย่างเท่าเทียมกัน (9 ข้อ), (4) ไม่ทำให้ผู้ป่วยเกิดอันตราย (12 ข้อ), (5) ปฏิบัติในสิ่งที่เป็นผลดีต่อผู้ป่วย (8 ข้อ), และ (6) ให้ข้อมูลที่เป็นจริงต่อผู้ป่วยและทีมสุขภาพ (5 ข้อ) ทั้ง 6 องค์ประกอบสามารถอธิบายความแปรปรวนได้ ร้อยละ 47.7 ซึ่งแต่ละองค์ประกอบมีค่าน้ำหนักอยู่ระหว่าง .45-.68 โดยแบบประเมินได้ผ่านการตรวจสอบความสอดคล้องภายในทั้งฉบับ พบว่า มีค่าสัมประสิทธิ์อัลฟ่าของ

ครอนบาค เท่ากับ .98 โดย เมื่อพิจารณาแต่ละองค์ประกอบมีค่าระหว่าง .84-.95 ทั้งนี้ได้มีการประเมินความตรงเชิงโครงสร้างด้วยการทดสอบสมมติฐานกับแบบวัดการให้คุณค่าเชิงวิชาชีพการพยาบาล พบว่ามีความตรงเชิงโครงสร้าง ($r = .54$, $p < .01$) และทดสอบความเที่ยงของแบบประเมินด้วยวิธีการทดสอบซ้ำ พบว่ามีค่าความเที่ยงอยู่ในระดับสูง ($r = .77$, $p < .01$)

แบบประเมินความมุ่งมั่นทางจริยธรรมของนักศึกษาพยาบาลมีความตรงและความเที่ยงซึ่งสถาบันการศึกษาสามารถนำไปใช้เพื่อประเมินความมุ่งมั่นทางจริยธรรมของนักศึกษาพยาบาลเพื่อออกแบบการจัดการเรียนการสอนในการบ่มเพาะจริยธรรมซึ่งจะนำไปสู่การปฏิบัติการพยาบาลที่มีคุณภาพสูงต่อไป

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ABSTRACT

This study aimed to develop the Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai) and evaluate its psychometric properties. The scale development process consisted of two phases: (1) the development of the MCS-Thai. Focus group discussions and literature reviews were used to generate 138 items with a 5-point Likert-scale format and (2) the psychometric evaluations of the MCS-Thai. Content validity index of the MCS-Thai was examined by five experts. The item-level content validity index (I-CVI) ranged from 0.8-1.0. The scale content validity index with universal agreement (S-CVI/UA) was .90 and scale content validity index with average (S-CVI/Ave) was .92. To determine its internal consistency using Cronbach's alpha coefficient reliability, the result was .98.

The MCS-Thai was administered to 809 senior baccalaureate nursing students from 10 nursing schools in Thailand. Exploratory factor analysis (EFA) with varimax rotation was performed. The result of EFA was six factors which comprised 81 items. The six factors were labeled as: (1) respect patient's privacy and keeping

patient's information confidential (22 items), (2) respect for patients (25 items), (3) providing care equally to each patient (9 items), (4) causing no harm to patients (12 items), (5) doing good for patients (8 items), and (6) telling the truth to patients and healthcare team (5 items). It accounted for 47.7% of variance and factor loadings ranged from .45-.68. The internal consistency was determined, yielding an alpha coefficient of .98 for the total scale and ranged from .84-.95 of each factor. Hypothesis testing supported construct validity (r = .54, p < .01). The stability reliability of the scale was examined by test-retest method and supported with high correlation (r = .77, p < .01).

The MCS-Thai is a valid and reliable instrument which can be used by nursing schools to assess moral commitment of nursing students in order to design nursing education for moral cultivation which will result in high quality nursing practice.

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Chutima Perngyai

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CHAPTER 1

INTRODUCTION

Background and Significance of the Study

People in any society expect nurses to provide high quality care. The nursing profession requires ethical conduct of nurses in their nursing practice. Ethics in nursing has always reflected the care of nurses which is an important part of moral identity and might be tending to reflect on the moral actions (Davis, Tschudin, & Raeve, 2006; Kurpis, Beqiri, & Helgeson, 2007). Nurses who provide a high standard of care always use ethical principles which comprised respect for autonomy, beneficence, nonmaleficence, justice, veracity, and confidentiality as guidelines to perform moral actions (Beauchamp & Childress, 2013; Fry & Johnstone, 2008). The qualities of care that can be considered are related to ethical principles such as active listening, understanding in communication, responsibility, respect for others, and acting confidentiality (Kulju, Slot, Suhonen, & Leino-Kilpi, 2016). Nurses will perform the moral actions to which they have committed (Asahara, Ono, Kobayashi, Omori, & Todome, 2013). Therefore, the commitment to act of nurses underpinned ethical principles revealing understanding the difference between right/wrong and feeling free to perform moral actions while providing care to patients (Talbot, 2012).

Commitment is an intrinsic factor that stimulates an individual to take a course of action and make a promise both to oneself and others to do the best they can which will result in the attainment of some goal (Basavanthappa, 2011; Carpenter & Hudacek, 1996). Moral commitment depends on the intrinsic factors in

each person, and a high commitment zone is placed by honesty with the positive orientation of deep compassion (Etzioni, 1975). Moral commitment is one of four vital elements from the model of morality which was proposed by Rest (1994). The model of morality comprised moral sensitivity, moral reasoning, moral commitment, and moral action. Rest (1994) claimed that people with high moral commitment will put their moral values higher than others and perform moral actions. The moral commitment in a person who has a sense of moral responsibility and integrity will reflect a genuine desire to achieve moral outcomes (Fry & Johnstone, 2008). Facilitating factors which will enhance moral commitment include personal attributes, environmental influences, and a learner relationship system (Bastable, 2014). The moral character of an individual is enhanced morals conforming to motivations, desires, and actions to promote choices leading to excellence in practice (Crigger & Godfrey, 2011). Moral commitment in nursing students could be cultivated through role models and nursing ethics education (Alligood, 2014; Emerson, 2007; Fry & Johnstone, 2008; Hilli, Salmu, & Jonsén; 2014; Lyneham & Levett-Jones, 2016; Rungreangkulkit, Kotnara, & Tangpukdee, 2014; Sankaranarayanan & Sindhu, 2012). It can be concluded that nursing education plays an important role in the cultivation of nursing students' moral commitment in order to promote their moral behaviors.

In regards to the nursing profession, moral commitment is a prerequisite of nurses in performing ethical behaviors which can be described as a moral responsibility and the obligation of nurses for maintaining, protecting, and promoting the patient's dignity (Gastmans, 2013; Sjöstedt, Dahlstrand, Severinsson, & Lützén, 2001). Nursing students who perform certain types of actions in

accordance with moral obligations are defined as having committed to perform moral actions to patients (Asahara et al., 2013; Fry & Johnstone, 2008). High moral commitment in nursing students significantly correlates with the performance of moral action while providing care to patients. Nursing students are taking a role as a health professional who should be able to motivate as well as have the desire to perform good acts and be willing to act for the benefit of patients (Kulju et al., 2016). Nursing students with moral commitment will make an effort to focus on consistent behaviors and carry out moral actions despite obstacles (Grace, 2014; Kurpis et al., 2007). According to DeVillers & DeVon (2013), nurses who are morally committed always reflect the greater moral comfort and feel less moral distress.

Good nursing care aims to enhance the dignity of humans in all their dimensions and also succeeds in realizing this intention in practice (Gastmans, 2013). Without intrinsic factors of individuals such as moral commitment, nurses cannot provide good nursing care although they are knowledgeable people. Moral commitment plays vital roles in moral identity in order to behave morally (Kurpis et al., 2007). The daily actions of nurses can engage them in promoting the moral interest of patients, such as ensuring that patients are treated with fairness and respect, receiving relevant information concerning their care and treatment, having their cultural values and beliefs respected, receiving adequate pain relief, receiving adequate support from the system, and having their concerns addressed in a prompt and appropriate manner. According to Fitzsimons & Kelley (1996), nursing students are always looking for the key to ultimate success. They will not give up and they strive to keep the goal of nursing excellence. It could be noted that nursing students with a strong moral commitment will provide a high standard of care to patients.

Assessing moral commitment will be useful for guiding nurses and nurse educators in order to enhance and cultivate moral commitment in baccalaureate nursing students.

An intensive review was undertaken by searching for literature published in the electronic databases of CINAHL, PubMed, ScienceDirect, SpringerLink, and ProQuest from 2006-2017. The studies of ethics have focused on ethical dilemmas in practice, ethical challenges, ethical climate, and moral distress (Suhonen, Stolt, Virtanen, & Leino-Kilpi, 2011). Furthermore, most of the research about morals is related to moral sensitivity (Jordan, 2007; Kim, Kang, & Ahn, 2013) and moral judgment (Suzy, 2011). There was little research that was related to moral commitment. Accordingly, MacRenato (1995) used a phenomenological method to explore the definition of moral commitment through the experience of the participants. The results showed that moral exemplars were found to be collaborative, joyous, benevolent, spontaneous, and extensive, possessed continuous faith, ignored personal risk, and showed an excellent personality in contributions of self and morality. Another is the study about moral commitment by Sjöstedt et al. (2001) who explored the moral commitment of nurses to patients in a psychiatric setting. The results showed that nurses who were aware of responsibility reflected the autonomous moral actions for tending care, did not neglect patients and were aware of the negative effect on the patients. However, there was no study about moral commitment in nursing students, particularly no existing instrument has been developed underpinning the concept of moral commitment.

Nurses in the healthcare system, therefore, perform their roles for the patients' best interest with the high ethical standard. Nursing education aims to

prepare nursing students as good human beings to provide a high standard of care (Sankaranarayanan & Sindhu, 2012). In Thailand, the philosophy and objective of nursing education for baccalaureate nursing students are focused on morals (Thailand Nursing and Midwifery Council, 2017). The MCS-Thai, a newly developed tool, can be used to assess moral commitment for preparing nursing students, which is differentiated from other moral tools. The challenge of this study was how to cultivate and enhance moral commitment in Thai baccalaureate nursing students after moral commitment was assessed. The results of the development and psychometric evaluations of the moral commitment scale (MCS-Thai) will provide benefit for Thai nursing education and the nursing profession in the future.

Objectives of the Study

1. To develop the Moral Commitment Scale for baccalaureate nursing students in Thailand.

2. To evaluate the validity and reliability of the Moral Commitment Scale for baccalaureate nursing students in Thailand.

Research Questions

1. What are the components of the Moral Commitment Scale for baccalaureate nursing students in Thailand?

2. How valid and reliable is the developed Moral Commitment Scale for baccalaureate nursing students in Thailand?

Conceptual Framework

The conceptual framework of this research is composed of: 1) ethical principles, 2) concept of moral commitment, and 3) moral commitment to patient care**.** The details are as follows:

1. Ethical principles

According to Grace (2014), ethical principles are standard rules or guidelines to perform actions that are pursued from theoretical propositions about what is good for humans. Additionally, ethical principles are important considerations for all parties involved in clinical teaching and learning (DeVillers & DeVon, 2013).

In 1989, Beauchamp and Childress addressed the source of bioethical principles. Ethical principles underpin guidelines for professional ethics which comprised six ethical principles. These are defined in six clusters of moral principles which consist of respect for autonomy, nonmaleficence, beneficence, justice, veracity, and fidelity (Beauchamp & Childress, 2013; Fry & Johnstone, 2008). For the accomplishment of this study the moral principles are defined and outlined as follows:

1.1 Respect for autonomy

The principle of respect for autonomy refers to respect for an autonomous person, to acknowledge their right, to allow freedom of choices, and to take an autonomous action based on values and beliefs. In addition, this principle

refers to the freedom from control by others and the individual limitations which will affect the way of choices are made. Respect involves acknowledging the rights of a person to make decisions to enhance the person to act autonomously. Respect for autonomy is the duty of healthcare professionals to disclose information, to assess and ensure understanding and voluntariness, and to encourage decision making (Beauchamp & Childress, 2013). Internal limitations on patient autonomy are mental ability, consciousness, age, and disease whereas external limitations are the environment, nursing shortages, the lack of information for making choices, and financial support (Fry & Johnstone, 2008).

1.2 Nonmaleficence

The principle of nonmaleficence confirms an obligation not causing harm to others by causing pain, inability, mental suffering, and death. This principle focuses on the actions of people which are related to situations, acting, and/or not acting that result in the physical and emotional suffering or imposing risks on others (Beauchamp & Childress, 2013). The patients' suffering is not just in a physical aspect but also includes perception, emotional, spiritual, social and cultural aspects. The relief of suffering is essential to protect patients' dignity and to promote a patient's safety (Fry & Johnstone, 2008).

1.3 Beneficence

The principle of beneficence involves people's willingness to help others. This principle refers to a moral obligation to provide good to others. It refers to kindness, love, and action to benefit other persons. Some examples of the

beneficence concept are those such as protecting and defending others' rights, preventing harmful actions, removing the conditions that will cause harm to others, helping persons with disabilities, and rescuing others in danger situations (Beauchamp & Childress, 2013). The nurse's responsibility is to provide benefit to the patient including social, psychological, economic, and religious support because of the nurse's primary commitment which is to the patient's well-being and safety (Fry, Veatch, & Taylor, 2011). The concept of a patient's well-being is accounted for in relation to the best interest of the patient based on the values of the patient (Bandman & Bandman, 1995).

1.4 Justice

Fairness has been used to explain justice which is interpreted as fair, equitable, and appropriate treatment. Standards of justice are needed whenever a person expects benefits or burdens because of their circumstances (Beauchamp & Childress, 2013). According to Aristotle: The justice principle is concerned with equals must be treated equally, and unequals must be treated unequally (Beauchamp & Childress, 2013). Additionally, this principle is related to fair distribution while providing care to patients respectful and not discriminating among cultural, social, and economic status or personal characteristics. The nurse needs to consider the knowledge, education, and capabilities of a person, as well as the severity and complexity of the patient's condition (Fry & Johnstone, 2008). The principle of justice would require allocations that are not necessary to produce the most good but require producing equality when possible (Fry, Veatch, & Taylor, 2011). In the nursing profession, resources are difficult to distribute though nurses do by

respecting patients' rights and treatment options. However, the healthcare team will determine the condition of patients in order to provide treatment fairly to each patient (Bandman & Bandman, 1995).

1.5 Veracity (Truth-telling)

Veracity in the healthcare providers refers to comprehensive, precise, and objective communication of the truthful information in order to foster a patient's understanding. Healthcare providers have to manage the truthful information including in disclosure limitations, stage of disclosure, nondisclosure, deception, and even in lying to patients and their families (Beauchamp & Childress, 2013). The principle of veracity is defined as the duty to provide truthful information and not to lie or deceive others. Truthfulness is regarded as fundamental to building trust among individuals. The instances of incompetent and unethical care of healthcare providers should be reported for the protection of other patients when immoral behavior has been observed or suspected (Fry & Johnstone, 2008).

1.6 Fidelity

The principle of fidelity is defined as the obligation to remain faithful to the commitment of oneself. Fidelity is the certain obligations in building trust between the patient and nurse, such as keeping promises and maintaining confidentiality (Fry & Johnstone, 2008). Fidelity is the moral principles to keep faith and promises for maintaining relationships. The obligation of fidelity arises whenever the healthcare providers established significant trust with patients by keeping promises. However, healthcare providers have a treatment contract with

others and not only patients in order to find the best way for the patients (Beauchamp & Childress, 2013). Thus, in order to be faithful to the patient, the nurse should carefully consider the information that should be kept confidential and what the nurse can reasonably agree to keep confidential. It could be considered as the commitment of the nurse to patients (Fry & Johnstone, 2008). The confidentiality principle was focused on in this study.

Confidentiality is presented when one person discloses information to another, whether through words or other methods without first party consent. In the healthcare setting, threats to confidentiality also emerge in many institutions with the capacity to store and disseminate confidential patient information including medical records on file, drugs prescribed, and payment records. There still exists a gap in confidentiality in healthcare settings. An inadequate strategy to protect a patient's information through technology can affect a patient's confidentiality (Beauchamp & Childress, 2013). Nurses should carefully consider keeping promises and maintaining confidentiality which will help in building a trusting relationship between the patient and nurse (Fry & Johnstone, 2008).

2. **Concept of moral commitment**

James Rest (1994) developed the four components model of morality which comprised moral sensitivity, moral reasoning, moral commitment, and moral action. Moral commitment is one of the vital components for behaving morally.

The third component is moral commitment, which refers to given ethical values in competition with other values in making moral judgments. A person who puts their moral values higher than others is reflected in high moral

commitment. In particular, the desire of person for material possessions or a commitment to group norms before making a decision that is morally right (Rest, 1994; Vozzola, 2014).

Moral commitment depends on intrinsic factors in each person, the high commitment zone is placed by honesty with the positive orientation of deep compassion (Etzioni, 1975). The moral commitment of a person is a genuine desire and interest to achieve good moral outcomes (Fry & Johnstone, 2008). According to Rest (1994), an individual must perform moral sensitivity, moral judgment, moral commitment, and moral character to morally behave. In the nursing profession, moral commitment can be described as a moral responsibility and obligation to protect human rights which is the moral ideal for nurses' commitment to their patients (Sjöstedt et al., 2001).

Commitment in nursing is preserved as something which matters, involving intimate, personal, and caring relationships (Boykin & Schoenhofer, 2001). Moral commitments are inherent in theoretical frameworks for nursing students and nurses. These commitments also extend to nurse educators and researchers (Alligood, 2014). The concepts of commitment, sensitivity, judgment, and self-confidence are interrelated with moral competency of nurses (DeVillers & DeVon, 2013).

3. Moral commitment to patient care

Moral commitment is an intrinsic factor to maintain relationships, gathered from personal attitudes, values and beliefs influenced by general norms and conventions (Rodrigues & Lopes, 2015). A strong commitment to service is one of the critical values the nursing profession provides for the public (Basavanthappa,

2011). Professional persons such as nurses should be able to motivate and desire to do good things through willingness to act for the benefit of patients (Kulju et al., 2016).

Moral commitments are inherent in theoretical frameworks for nursing students and nurses for providing high standard of care (Alligood, 2014). Moral commitment is a prerequisite for healthcare providers in order to relieve a patient's suffering with genuine motivation (Sjöstedt et al., 2001). When nursing students have a genuine desire and interest to achieve good moral outcomes, they will integrate the sense of responsibility and commitment to achieve moral outcomes in providing care (Fry & Johnstone, 2008).

In the concrete situations, moral choices of nurses must be considered in order to perform specific moral actions for the patient's best interest (Reed & Crawford Shearer, 2012). Moral actions are guided by a desire of the nurse to want to do the right thing with an ethical wisdom. If they understand the internal moral voice, and use bioethical principles as the external moral voice, then both internal and external moral voices must be integrated (Haahr et al., 2014). Moral values are cherished and most highly internalized, articulated, and integrated into behaviors in clinical practice (Lyneham & Levett-Jones, 2016). Because of the strong commitment to patients, nursing students who cared for vulnerable patients as a moral duty felt themselves touched not only as professionals but also as a person (Gastmans, 2013).

Moral commitment to patient care based on ethical principles is composed of: (1) respect for patients involving informed consent (Faghanipour, Joolaee, & Sobhani, 2013), respect a patient's decision making (Osterlind et al.,

2016), (2) do not cause harm to patients especially involving physical and emotional harm (Choe, Song, & Kang, 2013; Mansbach, Ziedenberg, & Bachner, 2013), (3) do good for patients in providing high quality of care and keeping patient safety (Kapborg & Berterö, 2003; Zamanzadeh, Valizadeh, Azimzadeh, Aminaie, & Yousefzadeh, 2014), (4) provide care equally to patients which involves treating all patients fairly and not discriminating (Choe, Song, & Kang, 2013; Ramos, Brehmer, Vargas, Trombetta, Silveira, & Drago, 2015), (5) tell the truth to patients which involves providing truthful information and reporting (Dobrowolskai, Slusarka, Zarzycka, McGonagle, Pawlikowki, & Cuber, 2014), (6) respect privacy and keep a patient's information confidential from others and maintain a patient's privacy (Paavilainen, Lepistö, & Flinck, 2014).

4. **Focus Group Discussion**

The moral commitment to patient based on literature reviews and ethical theory might not be suitable for Thai baccalaureate nursing student. Therefore, it was important to explore the moral commitment to patient care which specified from Thai nursing students' perception.

The focus group discussion was conducted with Thai baccalaureate nursing students from the faculty of nursing and the nursing college. The guideline questions were developed based on ethical principles and moral commitment concept. Thematic analysis was used to identify the accordance in opinion about moral commitment to patient care of Thai nursing students after focus group discussion.

The six themes were emerged by the nursing students from the focus group discussion. The results of moral commitment to patient care which comprised 1) strongly determined to respect patients, 2) not causing physical and mental suffering, 3) intend to do the best for patients, 4) commit to providing care without bias, 5) provide only truthful information, and 6) willing to keep a patient's information confidential and maintain a patient's privacy.

The literature review about ethical principles and moral commitment to patients, and focus group discussions with nursing students were integrated to form the conceptual framework before generating the item pool.

The conceptual framework for MCS-Thai is shown in Figure 1.1

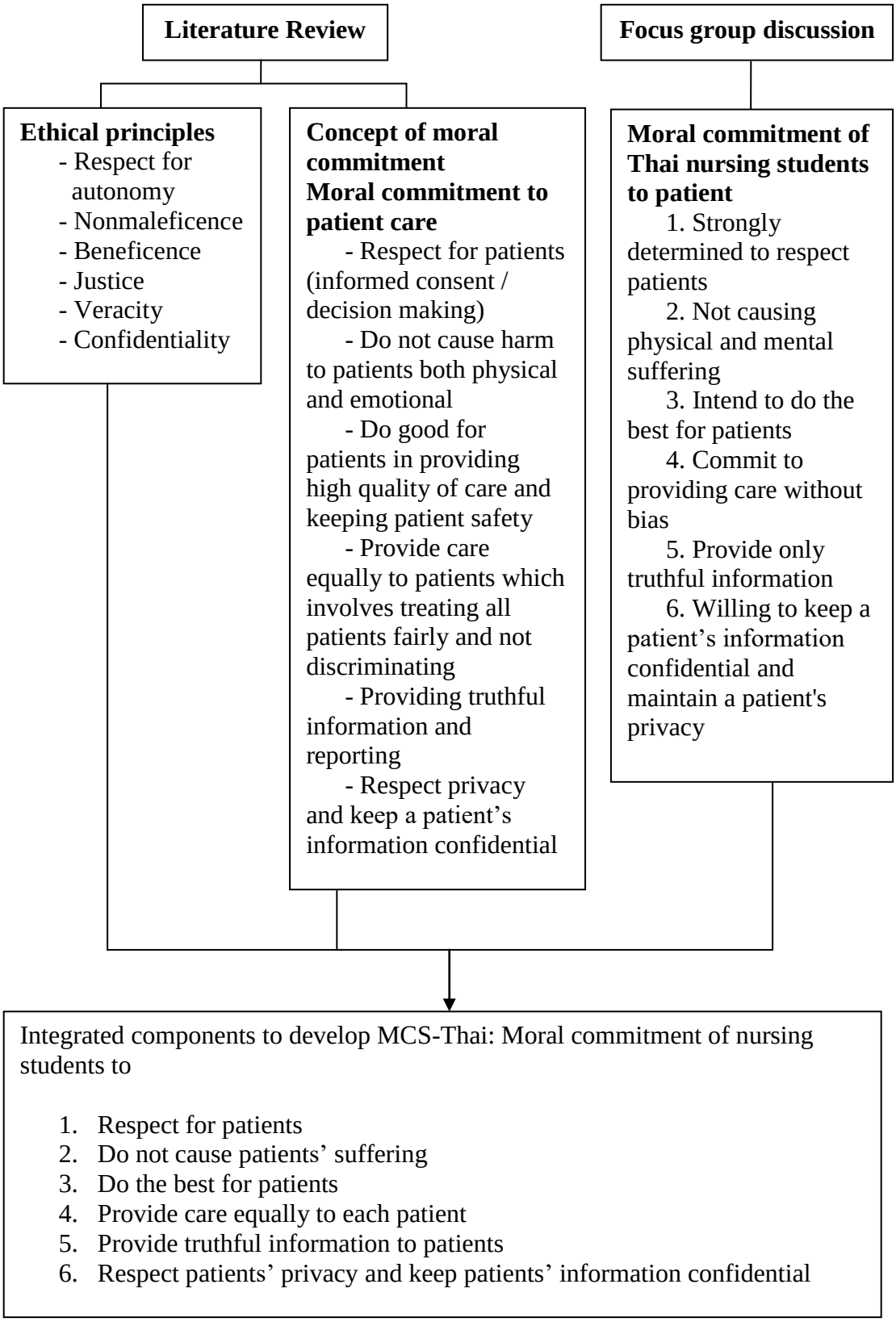

Figure 1.1 Conceptual framework of the MCS-Thai

A Norm-referenced Framework

In regards to constructing the MCS-Thai, the measurement framework is significant to guide the research design and interpret the scale by using a norm-referenced framework. A norm-referenced framework is commonly applied to develop a scale or a method to measure a specific characteristic which can discriminate among samples possessing different amounts of the characteristic of the study samples. This framework is used for assessing the performance of a sample relative to the others in some well-defined comparison with the norm group. In addition, the reference group might be the same sample, or it might be subjects nationwide to whom the same measure will be administered (Waltz, Strickland, & Lenz, 2017). For this reason, this framework is used to interpret the moral commitment scores of individual baccalaureate nursing students. The scores from using MCS-Thai will be compared among nursing students in Thailand. The nursing students with higher scores reflect higher moral commitment.

Definition of Terms

Moral commitment of nursing students refers to the affective domain of nursing students which will result in the obligation to perform moral action despite obstacles.

Moral commitment to patient care refers to the motivation to providing a high standard of care based on ethical principles which comprised

respect for autonomy, beneficence, nonmaleficence, justice, veracity, and confidentiality.

Moral commitment of nursing students to respect for patients refers to the intention of nursing students to obtain informed consent from patients in regards to the patient's health and treatment both positive and negative outcomes, respect patients' values and beliefs, and respect patients' decision making.

Moral commitment to do not cause patients' suffering refers to the determination of nursing students to not cause a patient to suffer physically, mentally, and socially.

Moral commitment to do the best for patients refers to the motivation of nursing students to provide benefits for patients in order to achieve goals based on the basic needs of patients and a high standard of care.

Moral commitment to provide care equally to each patient refers to the confidence of nursing students to give care to each patient based on the patient's needs, limitations of resources, and of providing fair treatment without discrimination.

Moral commitment to provide truthful information to patients refers to the willingness of nursing students to give only truthful information to patients about their health and nursing procedures which affect patients' decision making, and to report only the data that is correct based on the nursing student's knowledge or access to data.

Moral commitment to respect patients' privacy and keep patients' information confidential refers to the determination of nursing students to keep confidential a patient's information that does not have a negative effect on others,

respect a patient's privacy by not exposing a patient while providing care, and be careful not to post patients' information online.

Significance of the Study

The results of this research are significant and beneficial for various settings in the nursing profession:

1. Nursing education, the result can be integrated into ethics courses and the nursing curriculum. Assessing moral commitment in nursing students would be of benefit for nurse educators in order to design teaching and learning strategies for moral cultivation in nursing students.

2. Nursing research, the result of this study can help the researcher to use this instrument to assess moral commitment in nursing students as a guideline to enhance moral commitment which is useful in the nursing profession.

3. Nursing practice, the result of this research can be useful for nurse supervisors and nurses in clinical settings in order to assess the moral commitment of new professional nurses. This result are able to prepare and enhance moral commitment in providing care for achieving care based on the best interests of the patient.

CHAPTER 2

LITERATURE REVIEW

The literature review is very significant for the researcher in regards to exploring the empirical knowledge of moral commitment. Therefore, the researcher needs to review the relevant literature to construct the Moral Commitment Scale in Thai Nursing Students (MCS-Thai) which covers the following 4 topics:

1. Commitment and moral commitment
    - 1.1 Definition of commitment
    - 1.2 Type of commitment
    - 1.3 Model of morality
2. Moral commitment to patient care based on ethical principles
    - 2.1 Moral commitment based on respect for autonomy
    - 2.2 Moral commitment based on nonmaleficence
    - 2.3 Moral commitment based on beneficence
    - 2.4 Moral commitment based on justice
    - 2.5 Moral commitment based on veracity
    - 2.6 Moral commitment based on confidentiality
3. Factors influencing moral commitment in nursing students
    - 3.1 Nurse educator
    - 3.2 Nursing curriculum
    - 3.3 Teaching methods
    - 3.4 Moral character of nursing students
4. Measurement of moral commitment

Commitment and moral commitment

Commitments play vital roles in moral identity, especially commitment to perform moral actions. The definition of commitment, type of commitment, and model of morality are described as follows:

1. Definition of commitment

The concept of commitment is widely used in social psychology, management, marketing, and the other disciplines (Kurpis, Beqiri, & Helgeson, 2007). Commitment means intuition about the independent existence. It is explained by committed behavior and focused on consistently in the certain line of activity of the individual (Becker, 1960; Kurpis et al., 2007). The attributes of moral commitment are composed of empathy, feelings of obligation to help others, universal principles of justice and freedom, values of caring learned from parents, and connection to something larger than oneself (MacRenato, 1995). Commitment is used to explain the characteristics of people who have already ensured that one will follow consistent behavior. Even though there are several alternatives, a person who has commitment chooses the one which best serves their objectives (Becker, 1960; Tarkel & Duval, 1999).

According to Becker (1960), the elements of commitment consist of: 1) individuals make a decision with regard to particular actions which were not related to other interests and activities; 2) individuals place themselves according to their behaviors, and 3) the person who feels committed must be aware that they have to choose the way of making a decision and recognize the outcomes. Therefore,

commitment is motivation to take action based on values which are strongly associated with emotional readiness to put effort into achieving a goal (Bastable, 2014; Emerson, 2007; Marquis & Huston, 2012) in order to satisfy the psychological needs of individuals (Basavanthappa, 2011).

2. Type of commitment

Commitment can be divided into three types: continuance, affective, and moral commitment (Becker, 1960; Jaros et al., 1993) which are outlined as follows:

1) continuance commitment displays the sense of a person who is locked in a place and finds it difficult to leave. They will make decisions on a certain line of action without concern for the consequences or its relationship with any other activities.

2) affective commitment is revealed with the individual' s attachment and feelings of affection such as loyalty, warmth, belongingness, happiness, and pleasure. Then, they take action in their position as they wish.

3) moral commitment is the attachment of an individual in order to achieve their goals, values, and missions. The committed person must be aware that they have chosen and recognized the consequences after making the decision.

Moral commitment involves one's sense of moral responsibility and integrity in achieving moral ends (Fry & Johnstone, 2008). Moral commitment is associated with passionate feelings and inner conflicts which can act as motivation for continued commitment and service to others (MacRenato, 1995). Moral commitment can be defined as an internal focusing on the perception of intrinsic

barriers, boosting relationship maintenance regardless of external investments, barriers or constraints (Rodrigues & Lopes, 2015). For a person to perform certain types of actions in accordance with moral obligation is defined as commitment to taking moral decisions before action (Asahara et al., 2013; Fry & Johnstone, 2008).

Moral commitment is composed of pure and social aspects which are intensive types of commitment but have a different focus. Pure moral commitments are based on intrinsic norms and identification of each person, whereas social commitment is based on the pressure of people in society. Pure moral commitment aims to expand the relationships vertically, while social moral commitment tends to develop in horizontal relationships. Also, pure and social moral commitment might be found in the same relationships among individuals (Etzioni, 1975).

MacRenato (1995) conducted a study concerning experiences of moral commitment with four female and six male participants using interview. The findings showed the lived experience of moral commitment typically included: 1) become aware of the needs of others, and 2) choosing to serve others with compassion.

3. Model of morality

Morality refers to behavior of person that is accepted by professional standards, religious, societal, cultural, and ethical principles (Butts & Rich, 2013). Virtuous persons who have morality will perform certain actions better than others (Tarkel & Duval, 1999). Even if both affective and cognitive components of moral decision making and action are utilized, moral behavior is based on the personal idea that can be involved in a process of considered motivation to do good (Grace, 2014).

Morality is a complex phenomenon. Many components affect moral behaviors (Rest, 1994). Rest (1994) proposed the model of morality which addressed the ways to behave morally and approved the conceptualization of moral functioning. Rest viewed morality as arising from actions in actual situations that people in any society living together perform. Motivation may indeed result in priority setting before doing the right thing (Vozzola, 2014).

The Model of Morality is based on four components which were developed by Rest (1994). The four component model is presented as a theory of what determines moral behavior. The first component moral sensitivity, refers to the awareness of how our actions affect others. It involves being sensible in different actions and how responses from people in real situations interpret possible courses of behavior, determine who could be affected by these possible courses, and contribute to understanding how the affected parties would regard both positive and adverse effects (Rest, 1994; Vozzola, 2014).

The second component, moral judgment, refers to the way of thinking which alternative line of action is more defensible to people who lack ethical knowledge. It concerns making decisions about which possible courses of action are morally right in a particular situation. This component involves the domain of moral reasoning (Rest, 1994; Vozzola, 2014).

The third component is moral commitment which refers to given ethical values in competition with other values. A person who lacks moral motivation to put their moral values higher than others is reflected in the third component deficiency. In particular, a desire for material possessions or a commitment to group norm before making a decision that is morally right (Rest, 1994; Vozzola, 2014).

Motivation has also been described as the willingness of a person to judge and reflect the idea of being a virtuous person (Bastable, 2014; Christensen, 2009).

Moral character is the final component. It refers to the moral behavior of people despite possible obstacles and inspires one's own intentions. This element involves ego strength, endurance, firmness, and courage. The individual must have sufficient patience, self-strength, and achievable skill to follow through intentions (Rest, 1994; Vozzola, 2014).

Nowadays, Rest's model of morality is widely accepted in the field of ethics education and professional ethics (Crigger & Godfrey, 2011). Motivation is an intrinsic factor that affects an individual to take action and make a promise to do the best they can for the goal attainment of oneself and others (Basavanthappa, 2011; Carpenter & Hudacek, 1996). Many people are motivated by their own desires and specific achievements to fulfill their strong emotional response affirming whatever they have committed to do is right (Basavanthappa, 2011; Carpenter & Hudacek, 1996).

The affective domain of an individual is related to their perceptions of emotion, appreciation, and attitudes (Emerson, 2007). Inevitably, both affective and cognitive domains are significant components of moral behavior and may not be separated. Good action results from all components including sense, thought, and emotion (Grace, 2014). However, moral commitment is a critical element which motivates individuals to do the right thing after weighing personal values and moral values (Baxter & Boblin, 2007; Ebbeck & Gibbons, 2003). It could be noted that all components interact with each other and are presented in a logical rather than linear order.

Moral commitment to patient care based on ethical principles

In regards to the nursing profession, moral commitment can be described as a moral responsibility and the obligation of nurses to protect human rights. It is providing care in response to vulnerable people for maintaining, protecting, and promoting a human's dignity as much as possible (Gastmans, 2013). Ethics in nursing has always reflected habitual care of nurses (Davis et al., 2006). Nurses who care are genuinely humble in being ready and willing to know more about themselves and others. Commitment in nursing is preserved as something which matters, involving intimate personal and caring relationships (Boykin & Schoenhofer, 2001). Nurses who have genuine motivation will alleviate the patient's suffering as a result of their nursing commitment to their patients (Sjöstedt et al., 2001).

In 1989, Beauchamp and Childress located the source of bioethical principles which are shared by all persons in any society (Chadwick et al., 2011). Additionally, ethical principles can be assumed as guidelines for professional ethics (Beauchamp & Childress, 2013). The moral substance of nursing is fulfilled with compassion and empathy for vulnerable people through caring, security, and health promotion with a high standard of care focused on the dignity enhancement of people in society in all dimensions (Gastmans, 2013).

In the context of illness, respecting the autonomous wishes and choices of patients remains a central tenet of medical ethics. Medical care involves putting one's interest in the hands of health professionals, but in most cases it does not involve forgoing healthcare decision making and preferences entirely for others

(Chadwick et al., 2011). Nurses who have a strong commitment permit a patient to preserve character, values, and uniqueness, even though, the nurses have their own values in making arrangements to create choices for patients. Nurses have a responsibility to help the patient to understand the nature, extent, and possible outcome of treatment (Westrick, 2014).

Nurses' duty to patients is paramount as it places the needs of patients above all else including their own needs (Rumbold, 1986). Nurses who have a high level of responsibility will perform autonomous moral actions to avoid harming the patient due to neglect and distance from guilty feelings (Sjöstedt et al., 2001). Therefore, the moral commitment of nurses is fostered to act in the right way. Nurses who are morally committed and competent always reflect greater moral comfort and less moral distress (DeVillers & DeVon, 2013).

Due to their strong commitment to patients, nursing students who provide care for vulnerable patients motivated themselves to take moral action based on willingness for a high standard of care in nursing (Gastmans, 2013). Nursing students can assist clients to make informed treatment choices which include providing printed materials, videos, and interactive web-based tutorials (Bastable, 2014) including healthcare research, and the potential risk of harm to participants (Haahr, Norlyk, & Hall, 2014). Being morally committed to providing care to the patients is displayed as a vital component of nursing students.

Moral competence of nurses is the capacity to recognize what is positive or negative in specific circumstances and before reflecting on their feelings, making choices and acting to produce the most advantageous result for patients (Jormsri et al., 2005). Analyzing moral competence through the model of morality

comprises four components, although moral commitment has been noted as the vital component needed in order to act morally. It can be noted that the characteristics of moral competence have something in common with the moral commitment concept before behaving morally (Kulju, Slot, Suhonen, & Leino-Kilpi, 2016). The concepts of commitment, sensitivity, and judgment are interrelated with moral competence (DeVillers & DeVon, 2013).

Nursing students will feel and become a part of everything they encounter in their life including problems and frustration when they are truly committed (Clemence, 1966 as cited in Carpenter & Hudacek, 1996). According to Fitzsimons & Kelley (1996), a number of senior nursing students stated the key to their ultimate success was in their determination to achieve a goal. The encouraged students did not give up on their goal of nursing excellence as they sought out instructors and support services, made the school their own, became involved in every situation, and maintained hope. The moral commitment of nursing students to patient care based on ethical principles is described as follows:

1. Moral commitment based on respect for autonomy

Respect for autonomy refers to people being free and without control or interference from others. They have the right to make decisions based on clear information and are able to act autonomously (Beauchamp & Childress, 2013). Therefore, nurses should be available and prepare themselves for receiving and feeling strong emotions when patients refuse suggestions. It is important for nurses to be concerned about patients' questions and the probable effect on the patients and others (Sjöstedt et al., 2001).

Beauchamp and Childress (2013) mentioned that healthcare professionals are responsible to disclose information which included five components: (1) the truthful information that patients usually consider in deciding to consent or refuse treatment or research participation; (2) provide the proficient the information; (3) the recommendation from healthcare teams; (4) the objective of consent; and (5) the nature and limits of making decisions with authorization.

Accordingly, Boswell & Cannon (2011) mentioned the moral issue inserted in research is that the person has freedom of choice to participate in the research interest, and may withdraw from participation any time. This opportunity of choice is built on an arrangement of components and is composed of 1) language is simple and easy to understand 2) adequate comprehension of the study 3) the subject has had to consider potential drawbacks and benefits after discussing it with their family 4) the consent is not coerced from anyone 5) written consent was performed.

Bristol & Hicks (2013) stated that the informed consent process involving legal requirements is followed by the patient's consent by signature in the documents. The formal elements are incorporated into the disclosure of information and the capacity of the person in making decisions including understanding, and voluntariness. Informed consent issues were highlighted by Faghanipour, Joolaee, & Sobhani (2013) who conducted a descriptive research study in 7 hospitals with 300 patients who encountered critical situations with surgery. The their 12 questions revealed providing information, the sufficient level of information about the disease, surgery type, the positive outcomes and reason for the surgery, and the results of rejecting medical treatments such as risks and complications. The highest scores belonged to the risk of rejecting surgery followed by the characteristics of the

disease. The problem was the patients had not obtained sufficient information about procedures in the surgery process, the drug to be used such as anesthesia, the possible complications and negative outcomes from the surgery, other complementary treatments which require extra surgery, the duration time for admittance or rehabilitation, and the expenses involved. The lowest scores belonged to type of anesthesia and the process of follow up. Patients did not receive sufficient understandable information as information given was not adjusted for the level of the patient's education.

Another point concerning respect for patients was found by Moser et al. (2009) who examined how diabetes type 2 older adult patients made decisions by themselves and examined the moral capacities of diabetes specialist nurses (DSNs) supporting the autonomous decision making of patients. Grounded theory was used for data collection. Findings showed that diabetes specialist nurses (DSNs) can create and maintain a good relationship with patients. They also keep on track with patients even when they do not require care. Diabetes specialist nurses were committed to giving freedom of choice and sharing decision making with diabetes patients.

In addition, respect for patients by nursing students was studied by Choe, Song, & Kang (2013). Survey design was used to evaluate the acknowledgement of bioethical issues and ethical qualification in 1225 baccalaureate nursing students and 140 nurse educators. Different data collection methods were used for the two groups. The nursing students group filled out the paper questionnaires at school, while the nurse educators group answered online questionnaires via e-mail. The results showed that ethical qualifications in both groups showed respect for others. The positive score can be viewed as preparing

nursing students with good practice. It could be concluded that nursing students continue to think about respect for others because they want to be a nurse with the spirit of sacrifice and fulfillment.

In particular, nursing students must allow patients to nurture their character, values and beliefs, and uniqueness without concerning the values of other healthcare teams, thus, the patient can make decisions by themselves independently based on information from the health care team (Westrick, 2014). Nursing students should clarify the values of patients in addition to their own, while providing care to assess what is good or desirable, thus, influencing personalities and behaviors (Butts & Rich, 2013).

Respect for patients from nursing students has been highlighted in the study of Osterlind et al. (2016). They conducted research in Sweden with post first year baccalaureate nursing students on caring perceptions of dying people. The results found that although nursing students felt fear when they encountered a patient at the end-of-life and met with relatives, they continued to be respectful.

The cross-sectional study by Kim (2014) conducted research in Korean people at the end of life to determine whether finances and family influence decision making at the end of life. The participants were recruited from patients or families aged 20 years or over. They could read and answer the questionnaires by themselves at the ambulatory departments in hospitals. The results showed that Korean people preferred to make autonomous decisions by themselves at the end of life stage rather than relying on family, particularly in low-income families.

Respect for patients at the end of life was also studied by Rukchart, Chaowalit, Suttharangsee, & Parker (2014). Researchers conducted a qualitative

descriptive study with twelve patients who were interviewed individually by using case scenario to explore decisions and reasons of participants when they faced the proposed end-of-life scenario. Data were analyzed by using content analysis approach. The results showed four themes described patients' decisions and their reasons according to end-of-life consisting of: 1) forgoing life sustaining treatment because death is the fact of life which is inevitable/need peaceful death and not to burden family/society, 2) continuing life sustaining treatment because of the duty to prolong life/concern for family/fear of death/hope/unfinished tasks, 3) Allowing family to make decisions because families love me, they must know my needs, and 4) allowing physician/nurses to make decision because of trust in their competencies.

Besides providing standard nursing care, nurses perform moral actions for maintaining the best outcomes for patients based on their rights. This was reflected as a moral duty to advocate for their patient (Cole, Wellard, & Mummery, 2014). A human rights-based approach to vulnerability necessitates additional measures of protection (MacRenato, 1995). The concept of vulnerability aims to identify and categorize individuals, group and populations as vulnerable and trace the different forms of vulnerability that need to be overcome. It is also claimed that vulnerability is a universal principle because people that are incompetent are from vulnerable groups (Chadwick et al., 2011). In particular, vulnerable people such as pediatric patients, adult patients or aging patients who cannot make decisions by themselves, and psychological patients, for whom the nurse should act as the protector of patient's rights.

Noticeably, nurses should be identifying children's reactions in order to understand and propose some techniques in order to facilitate children's adaptation

to the new environment in the hospital. Peña & Rojas (2014) conducted research with pediatric patients aged 8 to 14 years old. Thirty participants were recruited in the study with observation and semi-structured interview technique based on the critical incident technique methodology. The results showed that pediatric patients in this study want to be told truthful information while some of them refused any information which will be better than perceived. Therefore, it is necessary to choose the appropriate way to provide information to pediatric patients. From the results of this study, the recommendations for nurses involved in determining how pediatric patients interpret the information and meanings depend on age and education level. The communication strategies and language used with children have a firm impact on the perceptions of pediatric patients and their families while admitted.

2. Moral commitment based on nonmaleficence

The principle of nonmaleficence means the obligation not to intentionally harm others by causing pain, disability, mental harm, and death which result in suffering or risks of suffering to others (Beauchamp & Childress, 2013). The patients' suffering includes physical, emotional, spiritual, social and cultural dimensions (Fry & Johnstone, 2008).

Ethics can be referred to concern for doing the right thing and avoiding any harm to patient while providing care (Paganini & Egry, 2011). Nursing shortages and human resources, patient's transfer to other places, and increased patients will affect the quality of care and patient safety. These issues also continue to have psychological effects on nurses such as moral problems which they

encountered both in nursing practice and quality improvement surrounding the workplace (Arries, 2014).

Fitzgerald & Hooft (2000) stated that nurses who have a different idea about their practice are also identified as competent healthcare professionals able to detect risk in order to serve the high standard of care for patients. They behaved as a professional nurse and showed willingness to choose the right action even though they perceived that it could be critiqued by others and effect professional caring. The willingness of nursing students was also revealed by Iacobucci, Barbara, Lindell, & Griffin (2012), when they conducted research with 47 senior baccalaureate nursing students. The research survey was conducted with convenience sample to assess the level of attitude using the Nurse Professional Values Sale (revision) which comprised 26 items and assessed the level of self-esteem (Rosenberg's Self-Esteem Scale) and comprised 10 items, the ethical decision making (PECS) was also used in order to assess the level of confidence which comprised 4 items. A significant positive correlation ($p< 0.05$) between nurse professional values and self-esteem was found. After reflection from nursing student experiences, they prepared themselves to resolve the moral conflict based on experience. They perceived confidence in doing the right thing which was revealed in making decisions. Self-esteem encourages nurses to behave morally for patient advocacy, despite encountering value conflict.

Besides caring, nursing students must have learned to confront the dilemma, interpret, and define well what a morally correct action is (Baxter & Boblin, 2007). Mansbach, Ziedenberg, & Bachner (2013) studied the willingness of nursing students to do the right thing such as blowing the whistle. Results confirmed that it is the responsibility of nursing students to protect the rights and well-being of

patients, which is a tool for advocacy. In addition, a study of nurses who worked in critical care and noncritical care units by DeVillers & DeVon (2013) found that moral conflicts most frequently reported were over aggressive treatment. This was followed by moral commitment fostered by acting in the right way based on concepts of commitment in order to take action resulting in moral comfort rather than moral distress.

Not causing harm to patients is also related to not neglecting patients in any situations. This was in accordance with Papastavrou, Andreou, & Vryonides (2014), who explored the nurse's experiences from their perceptions about priority setting while providing care, neglect for patients, and the reason for bedside nursing care. Twenty-three nurses participated in four focus groups using a semi-structured interview. Thematic analysis was used for data analysis. The results showed that nurses intentionally give priority to medical treatment or technical interventions more than performing caring relationships with patients. However, an ethical issue involving patient neglect occurred, as nurses' complained that negligence was impossible according to the nursing profession and their own values. This was supported by Sjöstedt et al. (2001) who found moral commitment to care for patients was an ethical issue. The results showed that nurses who were aware of responsibility reflected the autonomous moral actions for tending care, did not neglect patients and aware of the negative effect on the patients.

Awareness of risks is a significant topic while providing care as it is concerned about competency. Nursing students who were novices in clinical practice should be aware of their practice competency. Dobrowolskai et al., (2014) found that nursing students indicated a necessity to dedicate time and patience in giving care.

They were also aware of their own limitations and their limited ability to perform some activities. Furthermore, student's perspectives on behavioral expectations were found in a study by Wilk & Bowllan (2011). They held interviews with four focus groups to discuss the ideas and beliefs about a code of ethics (COE) and moral behaviors among nursing students concerning both ethical and unethical issues. The sessions lasted between 45 minutes and 1 hour. The results showed that nursing students adhere to professional codes of conduct and maintain patient safety as a priority in clinical performance behaviors.

Another study on the seriousness of bioethical issues which affected the ethical decision making ability of undergraduate nursing students was conducted by Choe, Song, & Kang, (2013). The survey design was used to assess the cognitive domain concerning bioethical issues and ethical qualification in 1225 baccalaureate nursing students and 140 nurse educators. Results revealed that 845 cases (69% of nursing students) were concerned that bioethical issues were somewhat serious, although 893 cases (79.2% of nursing students) demonstrated that they had some knowledge of bioethics. It could be noted that nursing ethics education should be developed consistent with the advancement of science and technology, raising the importance of ethical issues in enhancing the best education for professional nurses in the future.

It is undeniable that awareness of harm caused to patients by nurses is not only physical, but also emotional. Boonyamanee, Suttharangsee, Chaowalit, & Parker (2014) used qualitative design to explore the meanings and components of moral sensitivity of Thai psychiatric nurses in caring for psychiatric patients. Five psychiatric nurses working in psychiatric hospitals and drug dependency treatment

centers were given in-depth semi structured interviews. The interview transcriptions were performed using content analysis approach. Results showed that the awareness of the existence of ethical problems and identification of the situation are defined as moral awareness of Thai psychiatric nurses of patients' feelings and the effects of working with patients.

Protection of human rights is the most important topic which was raised for human research. Although the aim of individual research was different, the main point to determine is not to put any participants at risk. Haahr et al. (2014) stated that the potential risk of harm to research participants should be the least possible after weighing the benefits. Therefore, the protection of human's rights should be a major concern for healthcare research. Paavilainen, Lepistö, & Flinck (2014) mentioned the goal of moral conduct in research on family violence is for certifying participants' safety and ensuring extra risks are not caused to participants in the study.

3. Moral commitment based on beneficence

The principle of beneficence involves the willingness to help others. This principle refers to a moral obligation to provide good such as kindness, love, and action to benefit other persons (Beauchamp & Childress, 2013). The goals of healthcare professionals are inherently for the good of the patient and more broadly, social health. Being a good nurse is one tradition of philosophical ethics, which is concerned with the idea of virtues and means for good qualities of character such as admirable or desirable dispositions (Tingle & Cribb, 2014).

Beneficence is the obligation of healthcare providers to do good to others and help people in need (Avery, 2017; Bodenheimer & Grumbach, 2012). It is viewed as a duty to maximize benefits to patients while engaging in the role of healthcare providers (Grace, 2014). Inevitably, moral and professional obligations are served in the best interests of patients in care (Avery, 2017).

Caring is an important concept which could be described as focused attention on patient and engagement with the patient to determine personal needs and use of clinical judgment to meet those needs (Grace, 2014). The relationship with patients and helping others was important support which demonstrated caring in nursing students (Schmidt, 2016). The concept of caring among baccalaureate nursing students was explained by patients in the study by Labrague (2012) who conducted research with 174 patients admitted in the hospital. Data collection used Cronin and Harrison's Caring Behavior Assessment Tool which comprised 63 items with a 5 point Likert scale. The results showed the competency of caring among baccalaureate nursing students consisted of: (1) kind and attentive, (2) make patients feel good for self, and (3) provide treatments and medications on time. The highest score rated by patients was for the item to assist patient when they need help. The results also displayed the commitment of nursing students towards caring. An example of this was the paperwork they submitted including a handwritten journal, Nursing Care Plan (NCP) and informal record, and a self-evaluation on the integration of curative factors during clinical exposure.

Commitment for doing good to patients based on love was claimed by Fitzgerald & Hooft (2000) who revealed that love is a high level of caring that takes nurses beyond what caring indicates. It is a further aspect of commitment and

dedication to patients. The quality of love in nursing is demonstrated in commitment and intention to place the good for others before self and not needing anything in exchange. Besides providing care, good communication would be great for emotional support of patients and families who were suffering from illness. This was supported by Trisirirat (2014), who mentioned the usefulness and value of dialogue in creating humans, creating work and creating society. Dialogue can be used in education by promoting communication among teachers and students, among nurses and patients, and among health care professionals.

Accordingly, Dobrowolskai et al., (2014) found nursing and medical students view their practice of caring as care from the heart, attention to patient needs, tending, watching the patient to fulfill their needs, devoting attention and time, and longing for someone's good. Interestingly, the significant features of the participants in this study were committing their time to patients, showing interest in the person, and behaving in a manner which demonstrated empathy. Moreover, nursing and medical students made an effort in helping, being interested in the patients' condition, worrying about it, and being with patients. They understood the purposes of the care they gave and seemed to consider that care-giving was their main competence, likewise, with compassion to the patient. Compassion is generally focused on pain, suffering, disability, and the misfortune of patients. Nurses must understand the feelings and experiences of patients to respond appropriately to them (Beauchamp & Childress, 2013).

Furthermore, a study about the contribution of a good nurse's qualities and ethics towards the making of decisions was performed by Catlett & Lovan (2011). Subjects from three participating hospitals were recruited (one large regional

hospital and two small hospitals). The researcher independently contacted the participants to organize interviews. The participants were able to schedule a time and choose the place for interview by themselves. Before the interview, all participants also provided written consent for audio-taping and use of direct quotes for note-taking. The results showed that nurses' caring and caring behaviors revealed touching, showing kindness, providing good communication, and helping, being an advocate, and treating patients with care.

As a nursing professional, there are skills and outcomes expected in practice. Precision is the obligation of nurses in a specific area of practice (Mason, Leavitt, & Chaffee, 2012). Kapborg & Berterö (2003) showed the novice nursing students' viewpoint of caring. Caring comprised the three identified categories of doing, being, and taking a professional role. "Doing" could be identified as actions. It means that nurses are always present and perform activities with the patient. The analysis showed that doing consists of three categories: caring, assisting, and providing treatment. "Being" means that the nurses are always in the patient's mind. This term could be seen as concern for the patient divided into two dimensions: "being there" and "being with". "Professionalism" is divided into four subcategories: "knowledge", "rules and regulations," "'ethics," and "prevention."

A cross-sectional study was carried out by Zamanzadeh, Valizadeh, Azimzadeh, Aminaie, & Yousefzadeh (2014) in two faculties of nursing in Iran (Tabriz and Urmia) in nursing students in their first and fourth years of study (n=230) in 2012. Larson's caring questionnaires were used to collect data for assessing nursing care behaviors' significance. In the study the six dimensions of "being accessible, explains and facilitates, comforts, anticipates, trusting relationship, and

monitors and follows through" contained the total of 50 items. The result revealed that fourth-year nursing students were readily available and able to provide support, both physical and emotional, to patients and families. Additionally, professional competence was displayed by senior nursing students who felt confident that nursing tasks they delegated to subordinates would be completed. In addition, Boonyamanee et al. (2014) found that psychiatric nurses have great motivation to solve the problem and respond to the patients' need. They also had great motivation to provide good clinical practice based on the principles of right.

Sjöstedt et al. (2001) utilized an action research approach to deeper explore nurses' understanding of the significance of careful management of the first nurse-patient encounter in a psychiatric setting. The nurses in this study were interviewed and observed for data collection. Data analysis used content analysis. The results reflected on the moral responsibility of nurses for continuing the relationship between nurse and patient, and sustaining the nursing process. Nurses also reflected their willingness to act autonomously in order to maintain contact with their patient. The nurse and patient contract comprises the nurse being present for the patient in a relationship that flexibly develops and affects nurses' professional role subsequently resulting in moral commitment as the outcome.

Arpanantikul, Prapaipanich, Senadisai, & Orathai (2014) studied nursing administrators' perception of Thai registered nurses' professional ethics. 28 nursing administrators were purposively sampled according to specified qualifications and willingly participated in the study. Data collection was through taped in-depth interviews and field-data recording. Qualitative data were analyzed using content analysis method. The result pointed out those Thai registered nurses

classified ethics in the nursing profession as generosity toward patients, offering help altruistically, discipline, self-sacrifice, and service-mindedness and service behavior.

4. Moral commitment based on justice

This principle is related to providing care with fairness distribution to patients and not discriminating among cultural, social, and economic status or characteristics (Fry & Johnstone, 2008). Justice is a conception of importance which has close relationship with research, managed care, and disparities in health. In healthcare settings, justice is a fairness perspective of healthcare teams who tend to be directed toward the allocation of scarce resources to patients based on equal treatment (Grace, 2014). Justice mentions fairness and the equitable distribution of goods and a service particularly focusing on health law for the protection of the patients. Objectivity is essential in the contemporary healthcare climate when professionals correctly allocate the scarcity of medical resources (Bastable, 2014).

In some situations, fairness and equality established on impartiality and universal rules form the foundation of justice related to ethical decision-making for treatments (Haahr et al., 2014). Similarly, Toren & Wagner (2010) claimed that nurse managers were required to apply the justice principle which is distributed fairly in any administration. Moser et al., (2009) found that diabetes specialist nurses (DSNs) kept track of patients even when they were required less for caring. Nurses were still committed to giving freedom or participating as well as facilitating close engagement.

For healthcare professionals, equity is significant when considering how limited resources are to be fairly distributed (Avery, 2017). Ramos, Brehmer,

Vargas, Trombetta, Silveira, & Drago (2015) used questionnaire and focus group discussions with around 50 nursing degree students from three different intakes in a qualitative descriptive case study. The results noted that the moral intention or decision-making process included three central aspects which were inter-related in motion by the witness or experienced in ethical problems. Results showed that undergraduate nursing students experienced moral problems in primary care due to the equity in access to healthcare such as quality of care and receiving care without discrimination. They also had a tendency to offer various possibilities with regard to different values and beliefs that needed to be respected in order to fairly solve ethical issues.

Further supporting evidence from Choe et al. (2013), pointed out the principles of justice, in particular, women violations. In addition to nurse educators, nursing students in Korea are also important persons in safeguarding equality in society. Bioethics education curricula development pertinent to Oriental culture will empower the fairness in society for enlightening the lives of women and children. Another issue is fairness to AIDS patients because they experienced the double pain both for themselves and their family revealing shame, social stigma, and bias from people in society. The underdeveloped and developed countries are concerned with bioethics for AIDS patients regarding both political and social issues. Therefore, nurse educators and students should take a leading role in supporting and advocating for AIDS patients in order to provide equity of care.

5. Moral commitment based on veracity

Veracity or truth-telling in healthcare providers refers to comprehensive, precise, and objective communication of truthful information in order to foster patients' understanding (Beauchamp & Childress, 2013). This precept is used to explain people's feelings with regard to the need to tell the truth or whether deception is acceptable. Nurses should consider whether or not they need to tell the truth if it is done with the objective of beneficence (Marquis & Huston, 2012). In nursing practice, nursing students can give true information with regards to the delivery with the extent of the information necessarily adjusted for each patient (Grace, 2014).

Peña & Rojas (2014) found that the information from health care teams which reported feelings when given information or news, was motivating if pediatric patients received good news. Pediatric patients also presented psychological well-being by indicating that they were out of danger. Faghanipour, Joolaee, & Sobhani (2013) showed that it is important to provide essential information adjusted for the level of patient's education in order to understanding.

Furthermore, in the study by Dobrowolskai et al. (2014), the results found that medical and nursing students' use of listening and communication skills with patients was vital to answer their questions and explore their uncertainty about problems or illness. This was supported by Ion, Smith, Moir, & Nimmo (2016) who found nursing students understood that reporting their care concerns were an individual's responsibility who is accountable to both the patient and the profession, and not a personal choice.

Nursing students in the study by Wilk & Bowllan (2011) stated that they reported any clinical /professional concerns of health care teams, including being honest to report the mistake, and report any omissions of care. Additionally, Ramos et al. (2015) stated in situations of ethical conflict requiring moral deliberation before action displaying their abilities, nursing students saw themselves as actors or mere spectators.

Choe et al. (2013), founding that nursing students have an attitude of moderation to patients under care. Nursing students witnessed unethical situations particularly ethical issues that involved being more serious in critical situations. Nursing students who wish to be good nurses require the ability to strike a fine balance between thinking logically and understanding emotion.

Interestingly, Daniel, Adams, & Smith (1994) conducted a study with 191 nursing students who enrolled in five nursing schools in the Southern United States. Most of them were female and single. Data collection used a 37 item academic misconduct instrument and a 13 item clinical misconduct subscale. Results showed that academic misconduct in clinical settings revealed intentional disregard for patients' needs, whilst academic misconduct in the classroom disclosed to cheat on tests, hacking of materials, and not recording in nursing based on reality.

Krueger (2014) studied academic dishonesty in nursing students. Results indicated that nursing students who tended to cheat in the classroom were also likely to cheat in practice. They also did not report in reality and recorded inaccurately. Additionally, some of them admitted to breaking sterile technique, not correcting their mistakes and providing care without knowledge. However, a study concerning nursing students' willingness to blow the whistle by Mansbach,

Ziedenberg, & Bachner (2013) stated that whistle blowing in nursing students is taught both as an ethical issue and a tool for advocacy for giving the registered nurse means to encounter ethical dilemmas.

6. Moral commitment based on confidentiality

Confidentiality is a prevalent issue in daily practice. It is nurses' duty to ensure patient information is kept confidential except for the required purposes of planning treatment and providing care with a healthcare team (Finkelman & Kenner, 2013). This term is viewed as the securing of all private information which is obtained as a standard result of professional competence with a patient. The protection and privacy of information must be closely secured (Cannon, & Boswell, 2012). However, not all such information is given in confidence, it is also necessary to be satisfied with duty of confidence (Chadwick et al., 2011).

The obligations implicit in making a trust relationship between the patient and nurse concerned keeping promises and maintaining confidentiality which was reflected as one of commitments to patient care (Fry & Johnstone, 2008). Therefore, nursing students should be concerned about the patient's privacy and should not discuss patient's information in public areas where unauthorized persons can overhear (Finkelman & Kenner, 2013). Paavilainen et al. (2014) showed that it was important to keep patient's information in a safe place where others cannot access it. The data are kept in locked files should also be limited to a minimum number of authorized persons.

Ramos et al. (2015) highlighted the majority of moral situations that student nurses encountered concerning ethical problems while providing care

including keeping confidentiality and respecting privacy of patients. Nursing students have shown their commitment in the ethical decision making process. At first, they examine their feelings, knowledge, and values in deciding if the occurring ethical problems, influence the context, the people involved, the patient outcomes, the service and the nursing profession. The final stage is the intervention reaction of nursing students in attempting to resolve the problem.

In conclusion, moral commitment to patient care in nursing students includes the obligation to provide effective care and willingness to make a personal sacrifice. It is intended as a moral aspiration for praiseworthy performance above the average. It could be noted that a high standard of care results from the significant elements of moral commitment.

Factors influencing moral commitment in nursing students

Moral behaviors and professional of nursing students are commonly developed through the nursing curriculum and nurse professional values. There are various components for enhancing moral commitment in nursing students. Bastable (2014) stated factors that influence commitment can serve as either incentives or obstacles to achieve desired behaviors. All factors need to be considered in the context of the individual. Facilitating factors that shape motivation to enhance moral commitment include personal attributes, environmental influences, and learner relationship system. Therefore, factors influencing moral commitment in nursing students were categorized as follows:

1. Nurse educator

Moral education is making a cognitive and emotional investment with moral issues in nursing students. Nurse educators, as role models can encourage morals in nursing students through teaching, learning, and engaging in moral actions such as volunteer work (Kurpis et al., 2007). Moral exemplars were found to be collaborative, joyous, benevolent, spontaneous, and extensive, possessed continuous faith, ignored personal risk, and showed an excellent personality in contributions of self and morality (MacRenato, 1995).

Nurse educators have a moral commitment as teaching philosophers, role models, and theorists to provide an explanation of the intrinsic moral duty of theory usage through discussion and other means. Moral commitments which constitute certain theories should be stressed in addition to theory use importance (Alligood, 2014). Nurse educators are a key influence on students' understanding and embodiment of professional values. They can create a more humanistic learning environment in addition to becoming role models for learners by demonstrating their own cognition, perceptual-motor, and affective nursing through skill (Clark, 2008; Lyneham & Levett-Jones, 2016).

Nurse educators were previously seen as classroom managers responsible for assessment of learning methods, preferences, and problems (Clark, 2008). Recently, academics were seen to lead by example by using evidence-based practice through academic commitment and positive attitudes to foster evidence-based practice in academics. By modeling, nursing students could generate an interesting area of practice and create love for practice based on evidence-based practice (Malik, McKenna, & Griffiths, 2016). In Thailand, for the strengthening of

nurse educators in nursing schools both faculties of nursing and nursing colleges as methods of improving the quality of nursing graduates. These assessments include of reducing the shortage of nurses, raising appropriate income and welfare for nurses, planning for nursing career, and improving the opportunities in training and continuing nursing education (Srisuphan, Senaratana, Kunaviktikul, Tonmukayakul, Charoenyuth, & Sirikanokwilai, 1998).

The educator acts as a resource for students by asking questions and supporting learners' responses, encouraging students to arrive at their own decisions and engaging in self-assessment about clinical practice. Accordingly, Christensen, Barnes, & Rees (2007) proposed that reflection and moral exemplar methods were more effective to enhance moral commitment in nursing students. This is similar to Hilli, Salmu, & Jonsén (2014), who stated good mentors are based the ethics of caring. Mentors who feel comfortable in the position have the motivation and drive to welcome students into a relationship with care.

However, the rights and responsibilities of a faculty teaching clinical courses have both legal and ethical origins. For the preparation of the nursing student's competency, a faculty needs to understand the policies and procedures that impact on students, clinical agencies, and their role as nurse educators (Emerson, 2007). Nurse educators encourage students to be curious about practices by asking meaningful questions, finding relevant evidence and applying it to patients (Malik et al., 2016).

Nurse educators should act as good exemplars to enhance moral commitment while providing care to patients, and take action as effective members of a health care team. Nursing students rely on nurse educators to provide role

models and mentors. According to Rungreangkulkit, Kotnara, & Tangpukdee (2014), the characteristics of nursing instructors could develop enjoyment and the will to learn in students by the application of various techniques. For example; paying attention to the student's feelings, using adult learning methods, stimulating and challenging appropriately, and providing feedback since these are very important in promoting a passion in nursing students for their chosen field.

2. Nursing curriculum

Moral commitment depends on reinforcement from the social environment and changes (MacRenato, 1995). Nursing ethics has rapidly developed since the early 1980's and is now treated as an established discipline that forms part of applied ethics (Gastmans, 2013). Ethics courses tended to provide a foundation to expand perspectives, to assist and maintain opening of minds, and to create awareness of people in the nursing profession (Bowen, 2010).

Nursing education plays an important role in the cultivation of nursing students' moral commitment in order to promote their moral behaviors. In Thailand, an ethics course is important to cultivate morals through nursing education. The philosophy and objectives of nursing education for baccalaureate nursing students are focused on moral competence. This is consistent with the standard of nursing education at bachelor degree level which proposes moral competence as the first priority of learning outcomes (Thailand Nursing and Midwifery Council, 2017).

It is important to look beyond to the class schedules, assignments, and student life for an exciting nursing profession in 21st century. Health care reform is blooming in order to accompany social, demographic, and economic factors

(Meehan, 1991). The nursing curriculum is preparing nursing students with the essential cognitive, psychomotor, and affective domains for fulfilling responsibilities during their upcoming career in the nursing profession (Sankaranarayanan & Sindhu, 2012). Nursing theories supply the cognitive knowledge and will to accept the necessary decision making (Sjöstedt et al., 2001).

The nursing organization is assumed to develop and disseminate understanding of nurturing, living, and caring for persons as well as growing in caring (Boykin & Schoenhofer, 2001). This is supported by Lyneham & Levett-Jones (2016) who found that nurse professional values are the conceptualized standard for defining professional behavior and principles as a moral guideline that influences moral judgment and gives direction to clinical practice.

Nursing ethics is used to provide guidance on nursing activity in support of the assumed good (Bandman & Bandman, 1995). The effectiveness for preparing nursing students to progress through the three stages of moral growth comprised sensitivity, knowledge, and commitment. Nurse educators should introduce fundamental concepts for shaping ideas, provide theoretical foundations in course design, and continue to develop the psychomotor for practices through nursing ethics education in nursing schools (Warnell, 2010).

The purpose of teaching ethics is to enhance nurses' ability to analyze ethical conflicts encountered in practice and make more informed ethical decisions (Fry & Johnstone, 2008). A study by Kalaitzidis and Schmitz (2012) focused on a particular topic in ethics education taught to nursing undergraduates. The study purposed to reveal the significance of the ethical constituent of 'Ethics and Law applied to Nursing (topic NURS2104)'. The researcher allowed adequate period of

time for participants to reflect on ethics in nursing. Successful data collection emerged 1 year after the final clinical experience. The results showed significant correlation between ethics education and professional practices of the Bachelor of Nursing (BN) degree. Ethical decision making approaches had been successfully integrated into the topic (NURS2104). It became a significant topic which transformed the experience of nursing students.

Some studies have suggested considerable disappointment with respect to the actual implementation of the reform of a strong curriculum in conceptual foundations of ethics. Nursing education has to take considerable time for comprehensive transformation consistent with the healthcare system (Fry & Bi, 2013). Similar objectives in the teaching of medical ethics and research ethics were proposed by Sachs and Siegler, (1993). They claimed that the moral awareness of the moral problem in professional practice will be enhanced in ethical decision creating satisfactory consequences. Additionally, further benefit from both medical and research ethics can be derived from discussion of sensitive issues in situations that are non-threatening (Sachs & Siegler, 1993 as cited in Olson, 2010).

3. Teaching methods

Teaching becomes an ethical action and the practice of freedom when it is guided by a feeling of commitment to working with human beings to reach inside humanity or a willingness to reach toward an achievement (William, 2004). Moral developments have been inculcated through education for judging moral values such as honesty, truthfulness, justice, goodness, purity, courage, dutifulness, self-confidence, and discrimination between good and bad (Sankaranarayanan &

Sindhu, 2012). The pattern of knowing in nursing ethics is required and deepen understanding of different philosophical regarding what is good, what ought to be desired, and what is right (Reed & Crawford Shearer, 2012).

Traditional approaches to classroom teaching are being challenged to meet the demands of students, programs, employers of nurses, and the public. Nurse educators can ensure successful outcomes through the use of various teaching methods, teaching/ learning evidence in the classroom to guide content delivery and formative and summative evaluations (Cannon & Boswell, 2012). In addition, teaching in a clinical setting has been characterized by an informal teaching style rather than course outlines, lectures and written evaluation methods. The strategies used in a clinical setting include clinical conferences, case study presentations, and ethics rounds (Fry & Johnstone, 2008).

In nursing ethics education, some studies have found that efficacy can be enhanced through the use of problem-based learning (Lin, Lu, Chung, & Yang, 2010). The results of several studies were explained from the direct experiences of nursing students through a case-based method, using interdisciplinary teams such as physicians, nurses, social workers, and the chaplain who were all involved in patient care (Mularski, Bascom, & Osborne, 2001).

Ethics within the teaching realm moves toward the management of individuals. The teaching and utilization of ethical principles within the classroom or clinical experiences serves to serendipitously reinforce the students' capacity to distinguish individual values, to critically cogitate, and to act as a team (Cannon & Boswell, 2012). Various studies have found that higher levels of learning and assessment can take place in class time due to the provision of case-based learning

(Dupuis, Pharm, & Persky, 2008) and it also offers an alternative model to small-group teaching and more opportunities for clinical skills application (Srinivasan, Wilkes, Stevenson, Nguyen, & Slavin, 2007). According to Gaberson & Oermann (2008), discussions are an exchange of ideas in a small group format. Moreover, this method can provide a forum for students to express ideas, explore feelings associated with their clinical practice, clarify values and ethical dilemmas, and learn to interact in a group format.

Hsu (2011) focused on blended learning in ethics education in nursing students and revealed correlations between students' satisfaction with blended learning and case analysis attitudes were statistically significant. In addition, Warnell (2010) showed that developmental change requires integrated discipline. The results of this study supported were consistent with existing research which found that case studies, the inquiry of real-time scenarios through experiences of the students will allow for more understanding of conceptual perspectives. Moreover, it was consistent with current and emerging work in the field of moral reasoning.

According to Malik et al. (2016), the professional role model is to be one of the most fostering characteristics for clinical nurses in order to influence moral commitment. Teaching strategies also lead nursing students' learning and engagement with evidence based practice. Interestingly, teaching by confronting a real situation might enhance the learning ability of students. Iacobucci et al. (2013) showed that nursing students who experienced an ethical dilemma have a moderate confidence in ethical decision making. Values clarifications will help nursing students be able to identify conflicting values and know themselves the role expectations in the situation that they encounter.

In Thailand, Chaowalit, Hatthakit, Nasae, Suttharangsee, & Parker (2002) were concerned with a faculty of nursing being considerate in providing nursing students with diverse culturally appropriate ethical content and skills-training programs. The learning content is enhanced by discussion about the ethical issues, and practice of skills of ethical behavior in nursing practice. It could be noted that there is an intimate relationship between clinical and moral reasoning in nursing as optimum actions are ethically guaranteed while providing care.

4. Moral characters of nursing students

Moral character is refers to the moral action of people inspired by their own intentions. The elements of moral character involve ego, existence, stability, and courage. Individuals must have an inner strength, patience, and skill to follow their intentions (Rest, 1994; Vozzola, 2014). The virtuous agents have to regularly provide intrinsic motivation to strengthen their willingness to apply their greater abilities for the goal achievement (Basavanthappa, 2011). The idea of being a virtuous person is essential to the understanding of ethical reflection, judgment, and exemplifies moral competences (Christensen, 2009).

Inevitably, nurses are forced by self-esteem to advocate for patients faced with value conflict and help them to obtain a balance between personal and others values in the organization within the health professional identity. Morals rise from an individual sensitivity. They act as a guideline for moral behavior. The virtuous person is learned through education, experiences, and their socialization (Whitehead et al., 2010). Moral normatively is pre-given and common to all human

beings. The perception of common morality is universally binding (Chadwick et al., 2011).

Responsibility is a critical course to act morally because it is related to the moral basis of the sense of right and wrong as consciousness, and feeling free to choose values. Consciousness is necessary for decision making which based on values for action and freedom. It is reasonable to state that moral values are the foundation of moral action (Paganini & Egry, 2011).

According to Iacobucci et al. (2013), the professional nursing values of nursing students and self-esteem levels had a significant positive relationship ($p < 0.05$). This was despite students occasionally feeling low in self-confidence in relation to resolving moral conflict. Finally, in nursing students' experience, the most significant result from this study was doing what is right. However, self-esteem did not correspond with confidence in ethical decisions making. Additionally, there was no correlation between perceived confidence when making ethical decisions and the strength of nursing profession internal values. In this study, senior nursing students had high levels of self-esteem and nurse professional values.

Matherne & Litchfield (2012) studied the relationship between affective commitment and unethical pro-organizational behaviors (UPBs). The results of this study proposed that higher levels of unethical pro organizational behaviors result from increased affective commitment, and reduction in unethical pro organizational behaviors is caused by moral identity. Therefore, it is important for the director to understand the potential outcomes from people in their organization.

Since people are required to make various choices each day, many of them have ethical components to judge their own actions for regularity. However,

ethical judgments are based on their opinion and not right and wrong answers (Butts & Rich, 2008). Moral perception is sensitively charged before taking moral action in real situations (Huddle, 2005). Moral commitment is fostered to act in the right way. Nurses who are morally committed and competent always reflect greater moral comfort and less moral distress (DeVillers & DeVon, 2013).

In summary, clinical supervision by a good role model would be enhanced by moral perceptions in nursing students. They observe how mentors are held accountable and honest, and uphold appropriate practice standards. A strong curriculum in conceptual foundations of ethics, course opportunities for application within the core disciplines, teaching methods, and a moral agent who intended to maximize benefits to others are influenced by moral commitment in nursing students.

Measurement of moral commitment

In the research process, the standard theoretical framework is further characterized by multiple viewpoints and the range of measurements. Several studies developed instruments specifically for use in their study, however, it could be noted that the theoretical framework was inadequately explained as several studies did not mention the validity of the instruments. Most of these instruments focused on organizational ethics specific to the culture. Contemporary knowledge could be enhanced by cultural validation of the current instruments in various countries and the suitability for use in healthcare contexts for carrying out research in ethics organizations (Suhonen et al., 2011). There are scale developments and psychometric

evaluation research in various settings, the researcher will outline these in detail as follows:

1. Moral Competence Scale for Home Care Nurses (MCSHCN)

The Moral Competence Scale for Home Care Nurses (MCSHCN) was formulated by Asahara et al. (2013) in Japan on the basis of existing literature and a previous study. An open-ended qualitative survey was used to collect data from 55 HCNs, in addition to interviews with 8 HCNs. The self-administered questionnaire that comprised 90 preliminary MCSHCN items was disseminated to Japanese home comprising the following topics: “moral sensitivity (24 items), moral judgment (25 items), moral motivation (8 items), moral character (9 items), and implementing moral decision (24 items)”. Respondents were asked to rate their responses using a 5-point Likert scale. A higher score indicated a tendency toward a higher moral competence. Additionally, the content and face validity were established by seven experts and exploratory factor analysis was conducted to find the factor structure as the construct validity.

Results from exploratory factor analysis of the MCSHCN showed 45 items loaded on 5 corresponding factors. As a result factor 2 corresponded to moral motivation and moral character. In this study, Factor 2 was named: “Strong will to face difficult situations” comprising 11 items derived from theoretical elements of moral competence including: moral character (9 items) and moral motivation (2 items). This factor included moral motivation items that consisted of 1) “I try to positively face up to difficult situations where views clash”, and 2) “I try to take on new activities and broaden my efforts.” Correlations among factors ranged from 0.18

to 0.71. Five-factor contribution scores ranged from 3.93 to 12.81. As the internal consistency reliability, Cronbach's alphas ranged from 0.78 to 0.93. Therefore, the instrument was closely congruent with the theoretical components of moral competence.

2. Moral Competency Index (MCI)

Martin & Austin (2010) assessed the benefit of integrity-related determinations for use in people selection also test the validity of moral competency index (MCI) measurement. The participants were students in business classes from graduate and undergraduate degrees with a total 171 cases. An online survey was administered measuring the following ten competencies within a moral schema: "(1) acting consistently based on principles, values, and beliefs; (2) telling the truth; (3) confidence to do the right thing; (4) keeping promises; (5) taking responsibility; (6) admitting mistakes and failures; (7) willing to serving others; (8) active in caring about others; (9) report own mistakes; and (10) ability to let go of others' mistakes."

MCI results imply a participant's moral values and behaviors. In this study acceptable alpha levels were yielded from descriptive statistics and Cronbach's alpha. Principle Axis Factoring method was performed for extraction with factors extracted by Direct Obliging Rotation with 38% variance accounted for by the first factor alone. The eight variable factors established as a result of the factor analysis consisted of: 1) active care of others, 2) taking ethical action, 3) obligation to the truth, 4) self-forgivingness, 5) owning ones mistakes, 6) accepting own mistakes, 7) accepting others mistakes, and 8) having others trust. From this instrument, it is should be noted that the components involving moral commitment were active care

of others, obligation to tell the truth, and having others trust. However, the face validity of the MCI measure failed to establish the appropriateness of the scale.

3. Moral Justification Scale (MJS)

Some researchers described the instruments for measuring a variety of moral aspects such a moral justification in order to find out reliability and validity. Gump, Baker, & Roll (2000) validated the moral justification scale. This Moral Justification Scale (MJS), developed by Gump (1994), consists of six vignettes. Two stories were involved in justice, two stories concerned care, and two stories mixed both justice and care. Content validity index was assessed by eight experts and resulted in high for overall. Alpha Cronbach's reliability of the Care subscale was 0.75 and the Justice subscale 0.64. Test-retest reliability performed after two weeks showed moderate correlation of both subscales ($r = 0.61$ $P < 0.05$ for care and $r = 0.69$ $P < 0.05$ for justice). Therefore, the MJS may be beneficial instrument to measure moral justification based on Kohlberg's system for evaluation of justice orientation.

Hospital environments were commonly used in the majority of studies reviewed using the MJS since the 1990s. Ethical challenges, ethical dilemmas in practice, moral distress, and ethical climate form the focus of these studies. In addition, the instruments needed to clarify and provide clarity in concept and theoretical framework. The organizational ethics and the scope of the measurement in research needs to be increased (Suhonen et al., 2011).

4. Nurses Professional Values Scale-R (NPVS-R)

The original Nurses Professional Values Scale (NPVS) was developed based on *American Nurses Association Code of Ethics for Nurses with Interpretive Statements* in 1985 (Weis & Schank, 2000). In the 2001 *Code of Ethics*, nine provisions were delineated. Essential values and nursing commitments are central to the first three. Nursing duty and loyalty make up the next three. The final three provisions address the profession's social nature and responsibility in regard to the public. Therefore, the components of the *Code of Ethics* were established on values, and professional values resulting from a critical literature review (Weis & Schank, 2000; Weis & Schank, 2009).

The NPVS-R used a 5 point Likert scale comprising 26 items which ranged from 1 (not important) to 5 (most important), the minimum and maximum scores were 26 and 130, respectively. Higher level of internalized nurses' professional values was characterized by higher scores. Content validity was confirmed by four experts in Nursing Codes of Ethics. The experts comprised nurse educators and practitioners who had been previously involved in revision of *the Code of Ethics for Nurses*. They also specialized in professional values on which they have published, taught, and presented. Each of the 26 items in the revised instrument were individually checked for relevance and adequacy against nine code provisions comprising interpretive statements, readability, clarity, and meaning. Validity assessment of the NPVS-R was examined using factor analysis. The sample adequacy was assessed prior to conducting a factor analysis. The Kaiser-Meyer-Olkin (KMO) measuring sampling adequacy was .93, and Bartlett's test of sphericity indicated sample adequacy was statistically significant ($p < .0001$). The numbers of

factors in the composition of the PCA solution were determined by the following criteria: “(1) only those factors with an eigenvalue of 1 or greater were retained;” “(2) scree test, in which retained factors are those above the break;” and “(3) the result makes theoretical sense” (Weis & Schank, 2009). Items were retained according to a minimum factor loading of .40. The total percent of variance accounted for 56.7%. Internal consistency reliability of five factors with alpha coefficients ranged from .70 to .85 and the total scale alpha coefficient was .92 which supported findings. An overall factor loading from .46 to .79 spanning five factors supported construct validity. The five factors comprised “Caring,” “Activism,” “Trust,” “Professionalism,” and “Justice” (Weis & Schank, 2009).

From the literature review, although certain scales have been developed based on academic reviews and the agreement of experts, several scales lacked important concepts. For example, the MJS is not clear in its conceptual framework. For this reason, intensive reviews are needed before selecting a suitable tool for generalization. Interestingly, there are similarities in numerous points of the instruments reviewed such as the item pool generated based on moral philosophy (moral justification, moral competency, ethical theory, code of ethics) from the literature review and qualitative analysis from experts in both nursing and business fields, and the majority of the tools can be administered to participants by self-report via mail and several online. However, each instrument has different issues, particularly in regards to psychometric properties. For instance, MJS uses split-half and test-retest technique to test reliability, MCSHCN uses CFA while others instrument uses EFA. Moreover, NPVS-R tested construct validity using factor

analysis without other methods. The reliability was evaluated using only alpha coefficients.

Due to the strengths and weaknesses found in each instrument and the fact that no scale could measure moral commitment in nursing students directly, the MCS-Thai will be used to evaluate and plan for nursing education in the future. Inevitably, nursing education programs must be carefully examined and modified as necessary to ensure that graduates are prepared with the content and skills essential to work competently and confidently within a promptly changing, mainly unpredictable practice environment (Waltz & Jenkins, 2001).

In summary, the nursing profession requires ethical conduct of nurses in their nursing practice. Moral commitment is a prerequisite in the performance of moral behaviors by nurses and nursing students. Moral commitment to patient care will result in taking moral action without hesitation based on values and beliefs. Therefore, nurse professionals make choices with the goal of being a good nurse and doing good work. Good choices are ones that are ethically defensible and that benefit the patients and society. Nurses and nursing students provide care based on ethical principles in order to serve the high standard of care and maximize benefits to patients. Nursing students must be nurtured in moral commitment through the process of nursing education. Role models of nurses and the nurse educators can cultivate good morals in nursing students. Thus, understanding the significance of moral commitment in nursing is essential in designing a nursing ethics education to support the system to enhance moral competency development in nursing.

CHAPTER 3

METHODOLOGY

The purposes of this study were to develop the Moral Commitment Scale for Thai Baccalaureate Nursing Students and to evaluate the validity and reliability of the scale. The following questions were proposed: (1) what are the components of the Moral Commitment Scale for baccalaureate nursing students in Thailand? and (2) how valid and reliable is the developed Moral Commitment Scale for baccalaureate nursing students in Thailand?

The scale development guidelines of DeVellis (2017) and Waltz, Strickland, & Lenz (2017) were used to develop the MCS-Thai in this study. The study was divided into two phases: (1) the development of the MCS-Thai, and (2) the psychometric evaluation of the MCS-Thai. The details of each step such as sample and setting, instruments, data collection, the protection of human subject's rights and data analysis are described in this chapter.

Research Design

Methodological design was used to develop an instrument to measure moral commitment in Thai baccalaureate nursing students.

Phase 1: The development of the MCS-Thai

The objective of this phase was to develop the MCS-Thai. This phase comprised: 1) content domain determination 2) items generation, and 3) scale format determination. The details of each are presented as follows:

Step 1: Content domain determination

The purpose of this step was to clarify the concept of moral commitment and to determine the components of moral commitment. In this step, DeVellis (2017) suggested that the scale developer should have a clear idea of what is to be measured. The scale should be based on theory which is specific and obvious for creating item pools. Moreover, the researcher should be concerned about the reality of the situations in regard to generating items.

The first step in this study started with the exploration of moral commitment concept. The researcher gathered information on the components of moral commitment from literature review and focus group discussion with Thai senior nursing students, then the components from both sources were integrated to develop the conceptual framework.

Literature review

The aim of this review was to explore literature concerning the moral commitment concept. In this part relevant literature on the concept of moral commitment was reviewed. An intensive review was undertaken by searching for literature published in electronic databases including CINAHL, PubMed,

ScienceDirect, SpringerLink, and ProQuest from 2006 to 2016 by using the following keywords: commitment, moral, moral commitment, and nursing student to find information related to the concept of moral commitment**.** Additionally, all literature from nursing textbooks, nursing journals, non-nursing journals, and research reports related to moral commitment were also reviewed.

Focus group discussion with senior nursing students

The objective of the focus group discussion was to explore moral commitment experienced by senior nursing students.

Criteria of samples

Inclusion criteria of the subjects were:

1. fourth year baccalaureate nursing students

2. had recommendations from nurse educators as having moral action in nursing practice or won a moral award prize

3. able to communicate in Thai

Sample size and sampling technique

Ten volunteers were needed in this step to be research samples. Purposive sampling technique was used to recruit samples from 1 nursing college and 1 faculty of nursing. The researcher contacted nurse educators, within the nursing school to recruit samples based on the set criteria.

Instruments

1. The Demographic Data Form

2. The interview guideline. Components from the literature review were used to develop open-ended questions for the interview process.

Data collection

The researcher carried out focus group discussions of 45-60 minutes per group with two groups of fourth year baccalaureate nursing students. The informed consent form was given to the participants and permission also was sought to tape record the interviews.

Data analysis

The qualitative data was analyzed using thematic analysis (Braun & Clarke, 2006) to develop themes of moral commitment. The raw data was then drawn into themes.

Next, the components from themes of moral commitment from the focus group discussion and the components from the literature review were integrated to develop the components of moral commitment in nursing students. The operational definitions of each component were described.

Step 2: Items generation

The aim of this step was to generate the items pool. According to DeVellis (2017), items are generated by concept analysis, reviewing literature, clinical observations and interviews, qualitative methodologies, and selection from

existing instruments. In this study, items were generated from literature review and focus group discussion. A large number of items are a form of insurance against poor internal consistency. The authors must include more items than planned as in the final scale, the larger the item pool the better, a 10-item scale might involve a 40-item pool (DeVellis, 2017).

After integrating the components from themes of focus group discussion and the literature review, a large pool of items was generated within the scope of definition of each component of moral commitment.

Step 3: Scale format determination

The purpose of this step was to determine the format of the MCS-Thai. According to DeVellis (2017), Likert scale is a common item format which is presented as a relative sentence, following sample options that present varying degrees of agreement of the statement. Moreover, Likert scales are commonly utilized in regard to measurement of opinions, beliefs, and attitudes, and ultimately, the best one is the one that most accurately reflects true differences in opinions.

In this study, the MCS-Thai was designed to measure levels of moral commitment in nursing students. Moral commitment is the common sense psychology of virtuous agents who believe they are motivated by and act according to the values that they hold. Thus, it is suitable to use a Likert scale to measure moral commitment. All items statements were written in the Likert scale format and ranged from 5 (Most committed) to 1 (Very little committed). Scores were indicated as follows:

5 = Most committed

4 = Very committed

3 = Moderately committed

2 = Less committed

1 = Very little committed

The result of this step was the MCS-Thai version 1 (138 items).

Phase 2: The psychometric evaluation of the MCS-Thai

The objective of this phase was to determine the validity and reliability of the MCS-Thai. This phase comprised: 1) content validity determination, 2) pre-testing to evaluate reliability, 3) administration to study sample, and 4) final testing for construct validity and stability reliability.

Step 1: Content validity determination

The aim of this step was to evaluate the content validity of the MCS-Thai. The group of experts in validity determination should include individuals who know the content area well and should have expertise in measurement, and be able to evaluate the extent to which the items adequately measure the content domain or scale dimensions. Content validity demonstrates the universe of content which provides the foundation for item development that will adequately represent the content (Di Iorio, 2005; LoBiondo-Wood & Harber, 2014). According to DeVellis (2017), the reviewer serves multiple aims related to maximizing the content validity of the scale by confirming the definition of the phenomenon to rate how relevant

each item is which the authors intend to measure or in terms of CVI (Content Validity Index). There are two types of content validity index (CVI): I-CVI and S-CVI which are the most frequently used index in quantitative determination. The Scale Content Validity Index (S-CVI) was computed to evaluate the content validity of the scale whereas the Item Content Validity Index (I-CVI) was computed as the number of experts who score 3-4 on each item divided by the total number of experts (Polit & Beck, 2006; Waltz et al., 2017). The scores from the relevant scale are used for the calculation of the CVI using the formula developed by Waltz et al. (2017). In this step, to evaluate the content validity, data collection, and data analysis were performed as follows:

Samples

The samples in this step were content experts. The researcher asked the experts to review all the items on the questionnaire. The panel included five experts, comprising four nurse educators experienced in nursing ethics education and one nurse researcher experienced in scale development, who were asked to evaluate the relevancy, clarity and conciseness of the items in MCS-Thai version 1 (Appendix A).

Instruments

The MCS-Thai version 1 was used to determine relevance, clarity, and conciseness of the items. The relevancy was assessed by a 4-point scale: 1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, 4 = very relevant. The clarity of the items was determined by a 2-point scale: 1 = unclear and 2 = clear. The

conciseness of the items was evaluated by a 2-point scale: 1 = not concise and 2 = concise (Appendix B).

Data collection

The steps of data collection are presented as follows:

1. A letter from the Dean, Faculty of Nursing, Prince of Songkla University was sent to the directors of experts to request the experts' participation.

2. The researcher contacted each expert in person to explain the process of data collection after permission was obtained.

3. A letter from the Dean, Faculty of Nursing, Prince of Songkla University and the instruments were sent to the five experts who were asked to examine content validity of the MCS-Thai version 1.

4. The five experts were asked to rate their opinions on the degree of relevancy, clarity and conciseness of each item. If any experts rated relevancy at 1-2, they would be asked to give some relevant comments and suggestions.

Data analysis

In this study, the scores from the relevant scale are used for the calculation of the CVI using a formula developed by Waltz et al. (2017). Inter-rater agreement will be perfect when items are rated 3 or 4 by all experts, and the value of CVI is 1.00 (DeVellis, 2017). The CVI value of at least 0.8 is acceptable (Waltz et al., 2017). Inter-rater agreement was computed both at item level and for the total scale to determine which items would be dropped from the tool. The scale which composed of items with I-CVI = 1.00 and S-CVI/Ave of 0.90 when rated by five or

fewer experts was judged as having good content validity (Waltz et al., 2017). The I-CVI and S-CVI values greater or equal 0.80 are determined as acceptable content validity (Lynn, 1986; Polit & Beck, 2006; Polit, Beck, & Owen, 2007). Scale content validity index (S-CVI) indicates the scope of expert agreement and a value of .90 is the standard for good development in a scale's content validity (Polit & Beck, 2018).

The result of this step was the MCS-Thai version 2.

Step 2: Pre-testing to evaluate reliability

The objective of this step was to examine the internal consistency reliability of MCS-Thai version 2. Item analysis and internal consistency reliability using Cronbach's alpla coefficient were described.

Criteria of samples

Inclusion criteria of the subjects were:

1. fourth year baccalaureate nursing students
2. able to communicate in Thai

Sample size and sampling technique

According to Polit & Hungler (1995), at least 30 samples are an appropriate number for pre-testing. Purposive sampling was used to recruit baccalaureate nursing students who met the criteria. Therefore, 30 fourth year nursing students from a faculty of nursing and a college of nursing in Southern Thailand were invited to take part in this step.

Instruments

There were two questionnaires:

1. The Demographic Data Form

2. The Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai version 2)

Data collection

Data collection was divided into two phases: preparation phase and implementation phase.

Preparation phase

The research proposal was reviewed and approved by the Social and Behavioral Sciences Institutional Review Board (IRB) of Prince of Songkla University code PSU IRB 2017 - NSt 008 (Appendix C). The researcher submitted a letter and a document approved by the Institute Review Board (IRB), Prince of Songkla University to the dean/director of the faculty of nursing and a college of nursing in Southern Thailand to request permission for conducting research with 30 fourth year baccalaureate nursing students.

Implementation phase

The researcher directly contacted nurse educators in the two nursing schools and supplied them with data collection packages, the purposes of the study, questionnaire completion procedures and the consent form which were all explained. The protection of human subject's rights form (Appendix D),

demographic data questionnaires, and the MCS-Thai (version 2), were then administered to 30 fourth year baccalaureate nursing students. The nursing students had 2 weeks to complete the questionnaires. Anonymity and confidentiality were addressed for the samples in this step.

Data analysis

Item analysis and evaluation of internal consistency was performed in this step.

Item analysis

Item analysis is one of the statistical methods used for investigation of the item responses to each item of the scale and serves as guidance for revision to improve the effectiveness of the items and the validity of the scale (DeVellis, 2017). The items were considered for retention, revision or deletion according to the three criteria proposed by Nunnally & Bernstein (1994) consisting of: (1) the criterion level used for identifying and discriminating was items with level of factor loadings below 0.3, which were removed, (2) the item to total analysis had average correlations between 0.3-0.7, (3) internal consistency estimate should not decrease if the item was deleted.

Internal consistency evaluation

Internal consistency provides an insight into the homogeneity of the items, the relationships among the items, and inter-item correlations meaning that these items may be measuring the same concept (DeVellis, 2017). Cronbach’s

alpha value of 0.7 and above indicates sufficient internal consistency for the new instrument (Nunnally & Bernstein, 1994).

The result of this step was the MCS-Thai version 3 which was used in the step of administration to study sample.

Step 3: Administration to study sample

This step was aimed to evaluate item analysis, internal consistency and construct validity using exploratory factor analysis (EFA). After the MCS-Thai (version 3) was developed based on previously received feedback, the researcher administered the demographic data questionnaires and the revised MCS-Thai version 3 to the study sample.

Setting

The settings for this quantitative study were ten nursing schools including five faculties of nursing and five nursing colleges that were randomly selected from each region (Central, North, North-East, East, and South) of Thailand to make it representative of Thai baccalaureate nursing students.

Criteria of samples

Inclusion criteria of the subjects were:

1. fourth year baccalaureate nursing students
2. able to communicate in Thai

Sample size

According to DeVellis (2017), adequate sampling size is required in order to focus on a sufficient number of the items in particular for a new item pool. However, a number of subjects less than 300 might be sufficient if there is only a single scale to be extracted from a pool of about 20 items. Hair, Black, Babin, and Anderson (2010) mentioned that a ratio of about 5-10 subjects per item is accepted for psychometric evaluation of new instrument. Relying on Nunnally and Bernstein (1994) for psychometric evaluation of the new scale, a minimum of 5-15 subjects per item is recommended. However, there might be risks when using fewer subjects such as patterns of co-variation among the items may not be stable and the sample may not be a representative of the population for which the scale is purposed. Guidelines state samples of 100 should be regarded as poor, while samples of 200, 300, 500 and 1,000 should be considered fair, good, very good, and excellent, respectively (Comrey, 1973). To estimate sample size in this study, 5-10 subjects per item were selected.

Sampling technique

Two nursing schools, which comprised one nursing college and one faculty of nursing from each region of Thailand, were recruited using simple random sampling. The 10 nursing schools were as follows: Central region 2 nursing schools, North region 2 nursing schools, North-East region 2 nursing schools, East region 2 nursing schools, and South region 2 nursing schools. The samples were randomly selected from the list-name of fourth year baccalaureate nursing students.

Instruments

There were two questionnaires:

1. The Demographic Data Form
2. The Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai version 3) (Appendix E)

Data collection

The data collections were divided into two phases: preparation phase and implementation phase.

Preparation phase

The researcher contacted the dean/director of 10 nursing schools to ask for permission for conducting the research. The researcher sent a letter asking permission to collect data with the research proposal, which was previously reviewed and approved by the Social and Behavioral Sciences Institutional Review Board (IRB) of Prince of Songkla University code PSU IRB 2017 - NSt 008 (Appendix C), to the dean/director of a faculty of nursing and a college of nursing in each region. The name list of study samples was compiled by the nurse coordinators who were contacted by sending the letter including the questionnaires. In addition, several contacts were made between the researcher and nurse educators who were involved this process by using telephone, email, and other social networks such as Line and Facebook. After each nursing school gave permission, the researcher started to collect the data as previously. However, the protection of human subject's rights form needed to be administered to all samples.

Implementation phase

The researcher mailed 110 questionnaires and letters, containing the protection of human subject's rights form, instructions to answer the questionnaire, the demographic data form, and the MCS-Thai (version 3) to the dean/director of each nursing school. A total of 1,100 questionnaires were distributed to the subjects and the completed questionnaires needed to be returned within four weeks to the researcher.

Data analysis

Data analysis in this step comprised item analysis, internal consistency evaluation, and factor analysis.

Item analysis

Item analysis involves statistical methods which permit an examination of the response pattern of each item in order to guide effective revision of test items and test scores (DeVellis, 2017). The items were considered for retention, revision, or deletion according to the three criteria proposed by Nunnally & Bernstein (1994) as mentioned previously in the pre-testing step. Therefore, the items to total correlations of the MCS-Thai were determined for item analysis. Those items with correlations less than 0.3 do not sufficiently contribute to the total score, while items with correlations higher than 0.7 are probably redundant. Items to total correlation out of the range between 0.3-0.7 would be deleted. However, Cronbach's alpha coefficient estimate is a concern as it should not be decreased if those items are deleted.

Internal consistency evaluation

Internal consistency reliability is usually assessed with Cronbach's alpha coefficient, which is concerned with how much total instrument items assess the same notion (Polit & Beck, 2018). Internal consistency using Cronbach's alpha coefficient was conducted with MCS-Thai version 3. A high value of Cronbach's alpha reflects the high internal consistency and a value of 0.7 is acceptable for a new instrument (Nunnally & Bernstein, 1994).

Factor analysis

Factor analysis is a useful approach in assessing construct validity. It was designed using a conceptual framework, as a measure to assess various dimensions or subcomponents of a phenomenon interest, and a wish to empirically justify these dimensions or factors (Soeken, 2010). Construct validity was performed using Exploratory Factor Analysis (EFA) comprises two common aims: 1) to identify underlying dimensions of a construct in scale development and 2) to identify the item reduction in which a set of variables is summarized into the new group with a smaller number of variables (Hair et al., 2010).

Before running the EFA, the Kaiser-Meyer-Olkin (KMO) and Bartlett's test of sphericity must be performed. Kaiser-Meyer-Olkin (KMO) value was analyzed to determine the adequacy of the sample. KMO at 0.8 or higher shows sampling adequacy for the use of factor analysis (Dixon, 2005). Bartlett's test of sphericity tests the theory that correlations are zero within a correlation matrix. It was also used to determine the correlations of the items that did not emerge by chance

(Tabachnick & Fidell, 2013). Bartlett's test of sphericity is used to confirm that the original variables are correlated with each other (Dixon, 2005).

The EFA involved two phases consisting of: 1) factor extraction method using Principal Component Analysis (PCA), this method was performed because the results in the components were extracted from the real factors; and 2) factor rotation method using varimax rotation because of maximizing its loading on one factor and minimizing its loading on all factors (DeVellis, 2017; Hair et al., 2010).

Construct validity using the EFA principle as the method to identify the internal dimension of the MCS-Thai (version 4) was performed. The criteria for items evaluation of factor structure was based on the following criteria:

(1) An eigenvalue is equal or greater than 1. The reason for the eigenvalue determination as the criterion is that the magnitude of common variance elucidated by an extracted factor should be identical to the variation explained by a single variable (Ho, 2014).

(2) The scree plot tests criterion data points above the break. The initial factors extracted usually begin with large factors followed by a small factor. The purpose of this test is to discover the highest number of factors able to be obtained prior to the amount of unique variance commencing acquisition of the common variance structure (Ho, 2014).

(3) The percentage of variance explained at equal or greater than 50% of the total scale and equal or greater than 5% for each factor. The aim is to ensure that factors extraction is explained by at least a specified amount of variance.

Reaching a specific accruing percentage of total variance obtained by corresponding factors forms the basis of this approach (Hair et al., 2010).

(4) Factor loading cutoff point at equal or greater than .30 is considered to meet the minimal level to interpret the structure. The items with high factor loading ($\geq$ 0.3) might be claimed as significant. However, the researcher may find size loadings on more than one variable. Only one significant variable would be greatly simplified (Hair et al., 2010).

(5) Theoretical interpretability. The interpretability criterion is interpreting the essential meaning of the retained components and confirming that interpretation makes sense in terms of what is known about the constructs of the instrument (O'Rourke & Hatcher, 2013).

(6) Parsimony. An instrument needs to be parsimonious which comprises the minimum number of items that assess the factor sufficiently. It can be identified by relative items which have a strong relationship with a minimal number of factors (DeVellis, 2017).

(7) Internal consistency of each factor and the total scale at equal or greater than .70. Internal consistency is usually evaluated by calculating Cronbach's alpha coefficient. If the instrument has a high reliability coefficient it indicates the accuracy of the measure. The MCS-Thai was examined for internal consistency by using two measurements, Cronbach's alpha coefficient, and the alpha of the total scale (Polit & Beck, 2018).

The result of this step was the MCS-Thai version 4.

Step 4: Final testing for construct validity and stability reliability

This step was aimed to evaluate construct validity through hypothesis testing and stability reliability through test-retest method.

Construct validity determination by hypothesis testing

For all measures, construct validity is important to assess which relationships among the items included in the scale are consistent with the theory and defined concepts. Hypothesis testing was another type of construct validity which was used in this study.

Hypothesis testing examines the relationships based on theoretical predictions. Therefore, this study tried to test the hypothesis that the moral commitment of nursing students is positively correlated with professional nursing values. The Nurses Professional Value Scale-Revised (NPVS-R) identifies the components based on the *Code of Ethics* (ANA, 1985; 2001), values, and professional values (Weis & Schank, 2000; Weis & Schank, 2009). To assess moral values can be indicated as the moral action of the virtuous person or intention to perform moral actions. The NPVS-R is an instrument based on the Code of Ethics for Nurses that is commonly used to assess professional nursing values. Scale items are rated using a 5 point Likert scale that ranges from 1 to 5 (not important to most important), with scores between 26 and 130 for the total 26 items. A higher level of internalized professional nursing values is indicated by higher scores (Appendix G).

In Thailand, the Code of Ethics was primary developed by the Nurses Association of Thailand in 1985 and further developed in 2003 in order to guide nurses in Thailand to provide a high standard of care. The Code of Ethics for Thai

nurses was related to ethical principles for nurses to perform moral actions (The Nurses' Association of Thailand, 2003). According to Fry and Johnstone (2008), moral and non-moral beliefs, attitudes or standards are considered important to individual behavior and choices. Values are expressed by behaviors or standards that a person endorses or tries to maintain. For this reason, the relationship between the nursing profession values and moral commitment in nursing students was hypothesized to be in a positive direction. According to LoBiondo-Wood and Harber (2014), the correlation coefficient can range in value from -1.0 to +1.0. The relationship is indicated by a magnitude close to +1 which results in high correlation. A perfect positive correlation is indicated by +1.0 coefficients, thus a correlation of .76 shows a strong correlation between the variables. Consequently, to confirm the construct validity of MCS-Thai (version 4), hypothesis testing on the relationships between moral commitment and professional nursing values was verified.

Criteria of samples

Inclusion criteria of the samples were:

1. fourth year baccalaureate nursing students
2. able to communicate in Thai

Sample size and sampling technique

The sample for the hypothesis testing comprised 30 nursing students from one nursing school. Random sampling technique was used by the nurse educator. Then, the name list of 30 nursing students was selected.

Instruments

There were three questionnaires:

1. The Demographic Data Form

2. The Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai version 4)

3. The Nursing Professional Value Scale-Revised (NPVS-R).

Data collection

Data collections were divided into two phases: preparation phase and implementation phase.

Preparation

After a letter for asking permission to use the NPVS-R instrument (Appendix F) was received granting permission, the researcher performed the back translation process from English to Thai and Thai to English using three experts as follows: (1) a bilingual translator was used to translate the original version of NPVS-R into a Thai version without changes in the meaning of the original statements, (2) another bilingual translator was to back-translate the Thai version into an English version, (3) the English version in step 2 and the NPVS-R original version were compared by a native English expert in language. Finally, after the NPVS-R final version was reviewed by three experts, they concluded that the translated English version was accurate in meaning. Then, the Thai version of NPVS-R questionnaire (Appendix H) was provided to 30 nursing students.

The researcher sent the letter asking permission to collect data with the research proposal, which was previously reviewed and approved by the Social and Behavioral Sciences Institutional Review Board (IRB) of Prince of Songkla University code PSU IRB 2017 - NSt 008 (Appendix C), to the director of one selected nursing school asking permission from the director in regard to a research coordinator. Then, the researcher informally contacted a nurse educator acting as research coordinator to explain the plan and prepare for data collection, including sending the questionnaires back ensuring the confidentiality of the samples.

Implementation

Thirty nursing students were asked to complete questionnaire within 3 weeks and return it to the nurse educator acting as research coordinator in a sealed package. After that, the questionnaires were sent back to the researcher by the research coordinator before checking completeness of data was performed.

Data analysis

The correlations between the results of MCS-Thai total score and NPVS-R total score were examined by using Pearson Product Moment Correlation. The hypothesis could be accepted as having construct validity when a high correlation between two scales was discovered.

Stability reliability determination

In order to test the stability of the MCS-Thai, test-retest procedure was applied in this study because this method has been used for the stability

evaluation of a particular tool (DeVellis, 2017). This technique is appropriate for determining the qualities of a stable instrument over a period of time. Therefore, test-retest procedure is usually employed for investigating the reliability of an affective measure (Waltz et al., 2017). In this study, the MCS-Thai (version 4) was administered 2 times to the same group of senior nursing students within a 2 week period. The value of the reliability coefficient resulting from the test-retest procedure reflects the extent to which the measure ranks the performance of the subjects.

Criteria of samples

Inclusion criteria of the samples were:

1. fourth year baccalaureate nursing students
2. able to communicate in Thai

Sample size and sampling technique

The samples for the test-retest comprised 30 nursing students from one nursing school. Random sampling technique was used by the nurse educator. Then, the name list of 30 nursing students was selected.

Instruments

There were two questionnaires:

1. The Demographic Data Form
2. The Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai version 4)

Data collection

Data collections were divided into two phases: preparation phase and implementation phase.

Preparation phase

The researcher submitted a letter and a document approved by the Social and Behavioral Sciences Institutional Review Board (IRB) of Prince of Songkla University code PSU IRB 2017 - NSt 008 (Appendix C) to the director of the nursing school in Southern Thailand. Then, permission asked for 30 senior nursing students to perform the test-retest was granted.

Implementation phase

The demographic data form and the MCS-Thai (version 4) were administered two times within a two week interval to the same group of 30 nursing students. After completing the questionnaires, all subjects returned them within 2 weeks to the nurse educator acting as research coordinator in a sealed package. After that, the questionnaires were sent back to the researcher by the research coordinator before checking completeness of data was performed.

Data analysis

Correlations between the two set of scores for testing stability reliability were examined using Pearson Product Moment Correlation. A coefficient that is close to 1.00 refers to a more stable instrument (Burns & Grove, 2009; Waltz et al., 2017). A perfect positive correlation is indicated by +1.0 coefficients, a

correlation of .76 has a strong correlation between the variables (LoBiondo-Wood & Harber, 2014). The scores were obtained from both administrations on two different occasions and interpreted to assess stability.

The result of this step was the MCS-Thai version 5.

Protection of human subjects' right

The research proposal was reviewed and approved by the Social and Behavioral Sciences Institutional Review Board (IRB) of Prince of Songkla University code PSU IRB 2017 - NSt 008. Before collecting the data in the step of pre-testing to evaluate reliability, administration to study sample, and final testing for construct validity and stability reliability, a cover letter related to protection of human subject's right was composed including the objectives of this study, the voluntary nature of participation, assurances of the samples' confidentiality and anonymity by using a coded number on each questionnaire, and the benefit of the findings for the nursing profession. The return of a questionnaire was treated as consent to participate. The researcher provided her name, phone number, and email address for direct contact if any sample wanted to refuse or withdraw from this study after agreeing to participate (Appendix D).

Summary

The research procedures for constructing the MCS-Thai consisted of two phases: (1) generate items based on literature review and focus group discussions, and (2) determine content validity (I-CVI, S-CVI/UA, and S-CVI/Ave). Then, simple random sampling was used to recruit samples performing Exploratory

Factor Analysis (EFA) to determine factor structure of MCS-Thai. Hypothesis testing was used to test construct validity. Chronbach's alpha and test-retest were used to determine the reliability of the MCS-Thai.

Phase 1: The development of the MCS-Thai

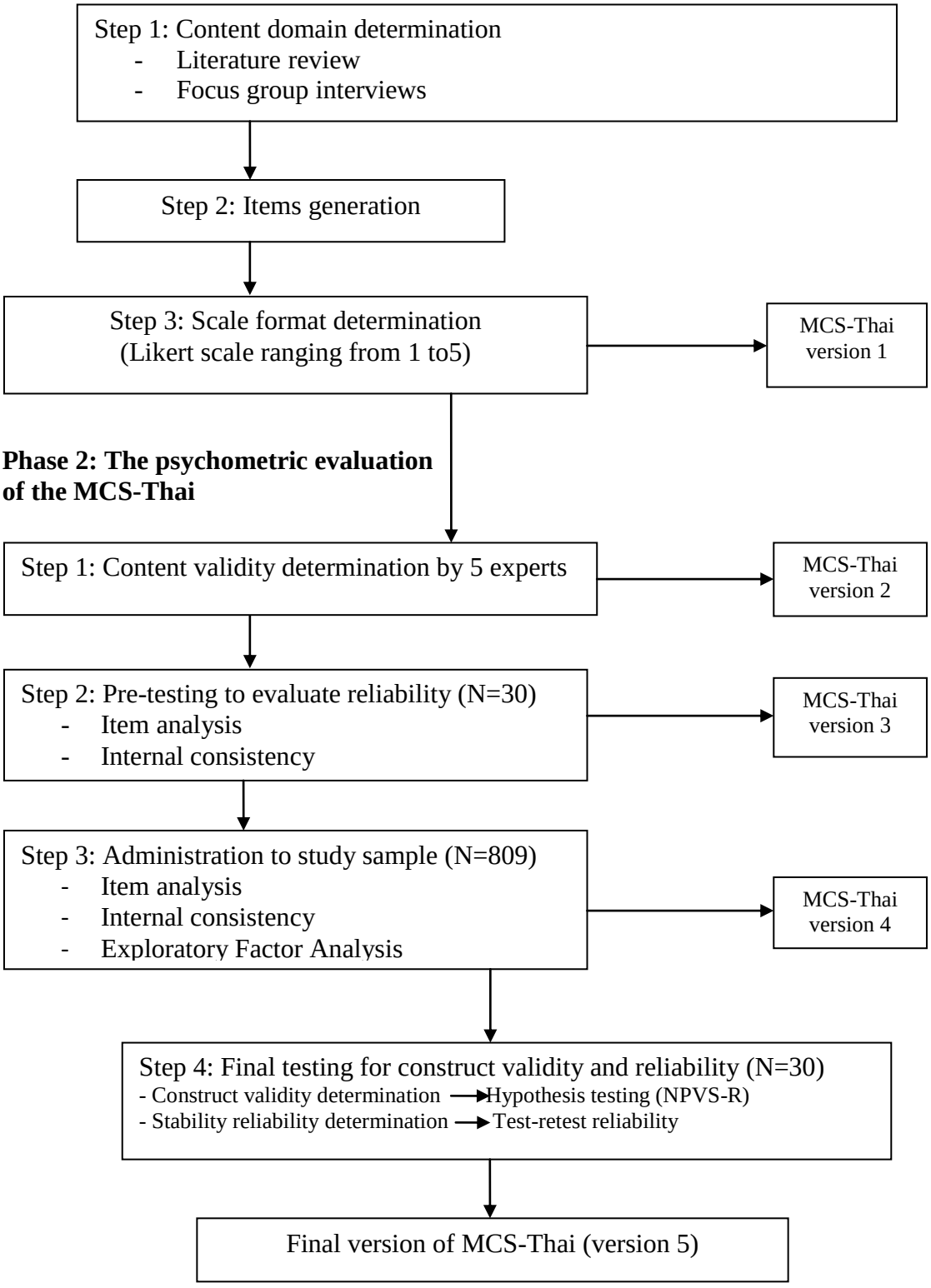

Figure 3.1 Steps in development and psychometric evaluation of the MCS-Thai

CHAPTER 4

RESULTS AND DISCUSSION

Introduction

The objectives of this study were to develop the Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai) and to evaluate its psychometric properties. This chapter presents the results of the processes for developing the scale and the outcomes of psychometric evaluation. This comprised two phases: (1) the development of the MCS-Thai, and (2) psychometric evaluation.

Results

Phase 1: The development of the MCS-Thai

The results of this phase were separated into three steps: 1) content domain determination 2) items generation, and 3) scale format determination**.**

Step 1: Content domain determination

The MCS-Thai was developed based on the following six ethical principles: respect for autonomy, nonmaleficence, beneficence, justice, veracity, and confidentiality (Beauchamp & Childress, 2013; Fry & Johnstone, 2008), and moral commitment which was one of the four components from the model of morality developed by Rest (1994). The literature related to moral commitment to patient care based on ethical principles was composed of (1) respect for patients revealing informed consent (Faghanipour et al., 2013) and decision making (Osterlind et al.,

2016), (2) do not cause harm to patients both physical and emotional (Choe et al., 2013; Mansbach et al., 2013), (3) do good for patients in providing high quality of care and keeping patient safety (Kapborg & Berterö, 2003; Zamanzadeh et al., 2014), (4) provide care equally to patients which involves treating all patients fairly and not discriminating (Choe et al., 2013; Ramos et al., 2015), (5) providing truthful information and reporting (Dobrowolskai et al., 2014), (6) respect privacy and keep a patient's information confidential (Paavilainen et al., 2014).

Six themes from focus group discussion were drawn using thematic analysis. The results illustrated moral commitment to patient care as expressed by the nursing students which comprised 1) strongly determined to respect patients, 2) not causing physical and mental suffering, 3) intend to do the best for patients, 4) commit to providing care without bias, 5) provide only truthful information, and 6) willing to keep a patient's information confidential and maintain a patient's privacy.

In this study, it could be noted that the results from focus group discussion were aligned with the result from the review literature concerning the 6 ethical principles and the moral commitment to patient care. The researcher integrated the components of moral commitment of nursing students to patient care which consisted of 1) respect for patients, 2) do not cause patients' suffering, 3) do the best for patients, 4) provide care equally to each patient, 5) provide truthful information to patients, and 6) respect patients' privacy and keep patients' information confidential. The 6 components of moral commitment to patient care formed the content domain for item pool generation.

The results of this step are detailed in step 2.

Step 2: Items generation

The six components of moral commitment to patient care were as follows:

1. Respect for patients: The first component comprised 28 items concerning respect for patients while providing care including giving useful information for making decisions, respecting patient's decision based on their values, beliefs, and needs, and enhancing family members to cooperate in the health care.

2. Do not cause patients' suffering: The second component comprised 19 items concerning not causing harm to patients including pain and suffering, and emotional harm while providing care.

3. Do the best for patients: The third component comprised 30 items concerning providing a high standard of care and maintaining patient safety, and caring for patients physically and mentally.

4. Provide care equally to each patient: The fourth component comprised 20 items concerning providing the fairness of care to each patient following nursing standard rights and not discriminating against patient.

5. Provide truthful information to patients: The fifth component comprised 19 items concerning telling truthful information to patients after having assessed the readiness of the patient and reporting based on fact.

6. Respect patients' privacy and keep patients' information confidential. The sixth component comprised 22 items concerning respecting patient's privacy and keeping patients' information confidential such as posting patient's photographs and information on social media.

Step 3: Scale format determination

A Likert scale ranging from 5 (Most committed) to 1 (Very little committed) was used for rating in the MCS-Thai. All items were written statements in the Likert scale format and ranged from 5 (Most committed) to 1 (Very little committed). The score was indicated as follows:

5 = Most committed

4 = Very committed

3 = Moderately committed

2 = Less committed

1 = Very little committed

The result of this step was the MCS-Thai version 1 which consisted of 138 items.

Phase 2: The psychometric evaluation of the MCS-Thai

The results of this phase are presented as follows:

Step 1: Content validity determination

From determination of the content validity index of MCS-Thai version 1, it was found that item-level content validity indices (I-CVIs) ranged from 0.80 to 1.00, S-CVI/UA (universal agreement) was 0.90, and S-CVI/Ave (average) was 0.92. At the end of this step, twenty-five items were deleted as they were unclear, not relevant, or not concise. Items with redundant content were assigned for deletion, while items with inappropriate content were allocated to be re-written according the expert's comments and suggestions.

The result of this step was the MCS-Thai version 2 which consisted of 113 items.

Step 2: Pre-testing to evaluate reliability

The results of this step are presented as follows:

Item analysis

All items displayed a level of item-total correlation between .30 and .79 which indicated that the items were appropriate to proceed to the next step.

Internal consistency

The alpha coefficient of the MCS-Thai 113 items (version 2) was .98 and the alpha coefficients of all components ranged from .90 to .92. The results of pre-testing supported the inclusion of the 113 items on the MCS-Thai (version 2).

The result of this step was MCS-Thai version 3 with 113 items.

Step 3: Administration to study sample

In this step, the researcher administered the demographic data questionnaire and the MCS-Thai version 3 to the samples.

From a total of 1,100 questionnaires, 870 (79.10%) were returned. Of the returned questionnaires, there were 61 (5.55%) excluded due to missing data. Finally, 809 (73.55%) questionnaires were analyzed. The ratio of item per sample was 1: 7.2.

Characteristics of the samples

It was found that the majority of samples were 21 years old (57.6%), female (93.9%) and Buddhist (94.1%). Forty-three percent had GPA between 3.01-3.5 and most of them (90.5%) had never received moral rewards. One quarter lived in the North-east (25.7%) and East (24.7%). Details are displayed in Table 1 below.

Table 1

Frequency and Percentage of the Samples Classified by Demographic Data (N=809)

Demographic data		Frequency	Percentage
Age			
	20	86	10.6
	21	466	57.6
	22	231	28.6
	23	18	2.2
	> 24	8	.9
Gender			
	Female	760	93.9
	Male	49	6.1
Religion			
	Buddhist	761	94.1
	Muslim	35	4.3
	Christian	12	1.5
	Other	1	.1
Domicile			
	North-east	208	25.7
	East	200	24.7
	South	199	24.6
	Central	113	14.0
	North	89	11.0

Demographic data	Frequency	Percentage
Grade Point Average		
2-2.5	78	9.6
2.51-3.00	313	38.7
3.01-3.5	352	43.5
3.51-4	66	8.2
Moral rewards		
Yes	77	9.5
No	732	90.5

Item analysis

The result of item analysis showed that only 1 item “I do not leave a patient asleep in bed for a long time” had an item-total correlation less than 0.3, therefore, it was eliminated from the scale. Finally, the 112 items with item-total correlation coefficients ranged from 0.32-0.68 were included.

Internal consistency

The alpha coefficient of the total scale was 0.98 and the alpha coefficients of all components ranged from 0.91-0.95.

Exploratory factor analysis

Exploratory factor analysis (EFA) was performed to determine factor structure of MCS-Thai version 3. The results are presented as follows.

Testing the assumptions of factor analysis

The Kaiser-Meyer-Olkin (KMO) and Bartlett's test of sphericity tested as the assumptions of EFA. The Kaiser-Meyer-Olkin (KMO) represented sampling adequacy at .98. Bartlett's test of sphericity reflected the overall significance of high correlations within a correlation matrix ($\chi^2 = 56781.996$, $p < .00$) which reflected the linear relationship of the variables. Therefore, the results of both the KMO and Bartlett's test of sphericity met standard criteria for further factor analysis.

Factor extraction using principal component analysis

An initial examination for factor extraction using an eigenvalue greater than 1 resulted in 17 factors with communality ranging from .45-.73. The total percentage of variance explained was 60.67. However, an examination of the scree plot (Figure 4.1) pointed out that four and five factors should be performed. Therefore, using a fixed number of factors such as factor 4, 5, and 6 were examined by orthogonal varimax rotation for factor loadings. The criteria for evaluating the number of factors which were retentions and extractions included: (1) an eigenvalue is equal or greater than 1, (2) the scree plot determination, (3) the percentage of variance explained at equal or greater than 50% of the total scale and equal or greater than 5% for each factor, (4) factor loading cutoff point at equal or greater than .30, (5) theoretical interpretability, and (6) parsimony of construct. Factor extractions were performed with 112 items of factor 4, 5, and 6 to determine the best factor structure of MCS-Thai.

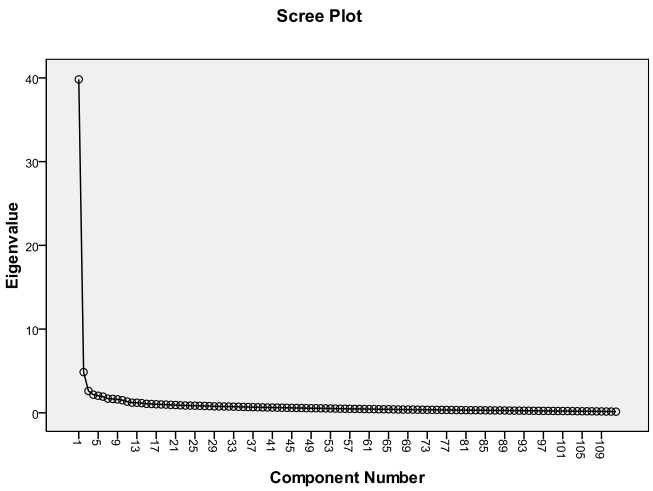

Figure 4.1 Cattle's scree plot of 112-item MCS-Thai

Note. Break in size of eigenvalues occurs between the fourth and fifth factors

Factor rotation using varimax method

EFA with four, five, and six factors were performed. The sixth factor of varimax rotation gave the best result since it met the set criteria as stated in chapter 3.

To achieve the theoretical interpretability and parsimony of construct, the criteria of factor loadings cutoff point from 0.3 to 0.45 were increased. at this step, 31 items were not loaded to any factors and then eliminated (item number: 1, 25, 37, 38, 39, 44, 45, 46, 54, 55, 57, 58, 59, 60, 61, 62, 63, 68, 70, 75, 76, 77, 78, 79, 80, 81, 86, 87, 89, 90, 91). After rotation, the MCS-Thai with six factors consisting of 81 items with factor loadings cutoff point at .45 and a total variance explained of 47.7% demonstrated the best solution. Moreover, all items had factor loadings ranged from .45-.68. The Alpha coefficient of the total scale was .98 and each factor ranged from .84-.95.

The six factors were: (1) respect patient's privacy and keeping patient's information confidential (22 items), (2) respect for patients (25 items), (3) providing care equally to each patient (9 items), (4) causing no harm to patients (12 items), (5) doing good for patients (8 items), and (6) telling the truth to patients and healthcare team (5 items) (Appendix I).

Factor I: Respect Patient's Privacy and Keeping Patient's Information Confidential

Factor I consisted of 22 items with factor loadings ranging from 0.50-0.68 and accounted for 11.43% of variance with an eigenvalue of 39.82. An examination of the item content (Table 2) revealed that the content of these items focused on the moral commitment of nursing students concerning patient's privacy and keeping patients' information confidential. In particular, nursing students were careful not to post photographs and information on social media which can result in a negative impact on the patient and family. Examples of items include, item 1: "I will carefully keep a patient's confidentiality during nursing care conferences," item 4: "I intend to keep a patient's secret without sharing it with others," item 17: "I will be careful not to expose the patient's body while providing care," and item 22: "I will not interfere with a patient's privacy unless it is related to their health." Thus, this factor was labeled "respect patient's privacy and keeping patients' information confidential."

Table 2

Items, Factor loadings, percent of variance, Eigenvalue of Factor I: Respect Patient's Privacy and Keep Patient's Information Confidential (N = 809)

Item no	Item statements (n = 22)	Factor loading
1	I will carefully keep a patient's confidentiality during nursing care conferences.	.68
2	I will keep a patient's secret if it will not harm others.	.65
3	I will keep information confidential while recording a patient's details.	.65
4	I intend to keep a patient's secret without sharing it with others.	.64
5	I will not reveal patient's information to others without the patient's permission.	.64
6	I will carefully keep patient's details confidential while reporting information to the next shift.	.63
7	I will not expose a patient's illness information to the others, besides health care members.	.63
8	I absolutely will not share any of the patient's information without permission from the patient.	.62
9	I will keep a patient's documents in a safe place.	.62
10	I will always ask a patient for permission before sharing his/her secret with others.	.62
11	If I have to show a patient's pictures for educational learning, I will hide the patient's name and characteristics.	.59
12	I will always ask what information that patient wants to keep confidential.	.58
13	I will not use a private telephone while talking about the personal information of patient.	.58
14	I will keep a patient's private information confidential.	.58
15	I will not mention a patient's name or patient's information in public.	.57

Table 2 *(continued)*

Item no	Item statements (n = 22)	Factor loading
16	I will log out from the system immediately after I have accessed a patient's information from a computer.	.57
17	I will be careful not to expose the patient's body while providing care	.56
18	I will expose only the part of the patient that I am providing care for.	.55
19	I will give patient's information to the health care team for medical treatment and nursing care.	.55
20	I will not post a patient's information online.	.55
21	I will not post a patient's photograph online.	.52
22	I will not interfere with a patient's privacy unless it is related to their health.	.50
	Eigenvalue	39.82
	% of variance	11.43%

Factor II: Respect for Patients

Factor II consisted of 25 items with factor loadings ranging from 0.46-0.63 and accounted for 10.46% of variance with an eigenvalue of 4.86. An assessment of the item content (Table 3) demonstrated that these items showed the intention of nursing students to show respect patients while providing care including providing information, respect patient's decision based on their values, beliefs, and needs, and encourage family members to cooperate in the health care. Example of items included, item 1: "I will provide care according to a patient's values and beliefs," and item 13: "I am ready to accept if a patient refuses my suggestions." Therefore, this factor was named "respect for patients."

Table 3

Items, Factor loadings, percent of variance, Eigenvalue of Factor II: Respect for Patients (N = 809)

Item no	Item statements (n = 25)	Factor loading
1	I will provide care according to a patient's values and beliefs.	.63
2	I will help patients to make autonomous decisions as they wish.	.62
3	I intend to help patients to take action after they make decisions.	.61
4	I commit to advocate for patients when they cannot protect their rights.	.61
5	I commit to protect patients from being insulted.	.58
6	I am very determined to protect vulnerable patients such as children, elderly, and psychiatric patients.	.57
7	I will promote patient's actions according to religious beliefs if it does not violate others.	.57
8	I am ready to accept the different ideas of patients if they are conscious and authorized in making decisions.	.56
9	I will promptly listen to patients' complaints and/or their questions.	.55
10	I will give information to the patients until it matches their needs.	.55
11	Whenever I give information to patients, I have to reassess whether they can understand very well.	.54
12	I do not pressurize patients to do anything if they do not want to do.	.54
13	I am ready to accept if a patient refuses my suggestions.	.53
14	I will respect patients' ideas and decisions even though I may disagree.	.53
15	I intend to help patients to make decisions consistent with their values and beliefs.	.53
16	I will always respect a patient's rights even if the patient is in a coma stage.	.52
17	I try to seek health information from reliable resources to assist patients.	.52
18	I am pleased to provide repeated information until the patient receives a clear answer without feeling bored/annoyed.	.51

Table 3 *(continued)*

Item no	Item statements (n = 25)	Factor loading
19	Before giving information, I have to ensure that the patient can perceive and understand it.	.50
20	Even though I disagree about patient's decisions, I will let him/her make decisions.	.50
21	I try to enhance family members to collaborate with health care team.	.50
22	I will cooperate with family members to search for a proxy person who can make decisions for the patient.	.49
23	I am pleased to provide repeated information until it is clearly understood by the patient.	.49
24	I will not try to use my ideas or beliefs to judge patients' thoughts or behaviors.	.47
25	I will give information every time when I provide care except in emergency cases for saving their life.	.46
	Eigenvalue	4.86
	% of variance	10.46%

Factor III: Providing Care Equally to Each Patient

Factor III consisted of 9 items with factor loadings ranging from 0.47-0.65 and accounted for 8.74% of variance with an eigenvalue of 2.61. An examination of the item content (Table 4) indicated that the content of items revealed the equity of care to each patient following nursing standard rights and not discriminating against the patient when providing care to them. Examples of items include, item 1: "I will provide care to all patients with the same nursing standards," item 3 "I will help all patients under my care to receive equal rights," and item 9 "I

will not discriminate in the care of a patient, even if they have a different opinion or belief." Therefore, this factor was labeled "providing care equally to each patient."

Table 4

Items, Factor loadings, percent of variance, Eigenvalue of Factor III: Providing Care Equally to Each Patient (N = 809)

Item no	Item statements (n = 9)	Factor loading
1	I will provide care to all patients with the same nursing standards.	.65
2	I will honor all patients equally.	.64
3	I will help all patients under my care receive equal rights.	.62
4	I will try my best to help all patients to be treated equally.	.61
5	I will treat all patients equally, regardless of educational level or social status.	.57
6	I will use polite and friendly words with patients.	.54
7	I will provide care to patients of different races or religions without bias.	.54
8	I will provide gentle care to every patient.	.51
9	I will not discriminate in the care of a patient, even if they have a different opinion or belief.	.47
	Eigenvalue	2.61
	% of variance	8.74%

Factor IV: Causing No Harm to Patients

Factor IV consisted of 12 items with factor loadings ranging from 0.45-0.58 and accounted for 5.99% of variance with an eigenvalue of 2.17. An assessment of the item content (Table 5) displayed the content of items concerning doing no harm to patients including pain and suffering, and emotional harm.

Examples of items include, item 3: “I will never let patients suffer from my actions towards them,” and item 5: “I am determined not to increase patients’ pain from my nursing practice.” This factor was called “causing no harm to patients.”

Table 5

Items, Factor loadings, percent of variance, Eigenvalue of Factor IV: Causing No Harm to Patients (N = 809)

Item no	Item statements (n = 12)	Factor loading
1	I will not get angry or irritated towards patients.	.58
2	I will not make patients feel more anxious while being admitted to hospital.	.58
3	I will never let patients suffer from my actions towards them.	.57
4	Even if a patient uses aggressive words and gestures towards me, I will keep calm.	.55
5	I am determined not to increase patients’ pain from my nursing practice.	.51
6	I will not use techniques or solutions that will cause patients’ more pain from wound dressing.	.51
7	I will not use suction techniques that cause suffering and pain to patients.	.51
8	I will not use words or actions that make the patient feel embarrassed or inferior.	.50
9	In case of intravascular injections, I will try to find the best way to reduce irritation.	.50
10	In case of sensitive groups such as AIDS patients, cancer patients, patients at the end of life etc., I will be careful in using words that may affect their feelings and emotions.	.50
11	I will not cause patient suffering because of my words.	.49

Table 5 *(continued)*

Item no	Item statements (n = 12)	Factor loading
12	I will be careful while working in order to prevent patients from being harmed or disabled.	.45
	Eigenvalue	2.17
	% of variance	5.99%

Factor V: Doing Good for Patients

Factor V consisted of 8 items with factor loadings ranging from 0.46-0.58 and accounted for 5.67% of variance with an eigenvalue of 2.03. An examination of the item content (Table 6) revealed that the items focused on providing high quality care and maintaining patient safety, and caring for patients physically and mentally. Examples of items included, item 1: "I intend to dedicate myself and time to help patients receive high quality care," item 3: "I am pleased and willing to take care of patients," and item 6: "I will take care of patients until I am sure that the patient is safe after medication is given." This factor was called "doing good for patients."

Table 6

Items, Factor loadings, percent of variance, Eigenvalue of Factor V: Doing Good for Patients (N = 809)

Item no	Item statements (n = 8)	Factor loading
1	I intend to dedicate myself and time to help patients receive high quality care.	.58

Table 6 *(continued)*

Item no	Item statements (n = 8)	Factor loading
2	I will take care of the patient throughout the duration of time, no matter how busy the work is.	.53
3	I am pleased and willing to take care of patients.	.53
4	I am committed to serving patients despite sacrificing personal happiness.	.53
5	I am ready to assist patients without being asked.	.50
6	I will take care of patients until I am sure that the patient is safe after medication is given.	.50
7	I will reveal understanding and concern to the patient.	.49
8	I will always cheer up the patients.	.46
	Eigenvalue	2.04
	% of variance	5.67%

Factor VI: Telling the Truth to Patients and Healthcare Team

Factor VI consisted of 5 items with factor loadings ranging from 0.46-0.56 and accounted for 5.42% of variance with an eigenvalue of 1.93. An examination of the item content (Table 7) showed that items emphasized providing truthful information to patients after having assessed the readiness of the patient, and reporting based on fact. Examples of items included, item 2: “I have to assess the patient's ability to accept the truth such a bad news,” and item 5: “I will write a nursing report on what I have done.” This factor was called “telling the truth to patients and healthcare team.”

Table 7

Items, Factor loadings, percent of variance, Eigenvalue of Factor VI: Telling the Truth to Patient and Healthcare Team (N = 809)

Item no	Item statements (n = 5)	Factor loading
1	I will provide clear and truthful information about patients' health until they understand very well.	.56
2	I have to assess the patient's ability to accept the truth such a bad news.	.54
3	I will report the mistakes of others.	.51
4	In cases where the patient needs information beyond my duties. I will coordinate with those involved in providing information to patients.	.49
5	I will write a nursing report on what I have done.	.46
	Eigenvalue	1.93
	% of variance	5.42%

Internal consistency reliability

The researcher performed internal consistency testing to assess the reliability of the 81-item MCS-Thai measuring the alpha coefficients of the total scale and the alpha coefficients of all the factors.

The results of the alpha coefficients of the MCS-Thai (version 4) are shown in Table 8.

Table 8

Alpha Coefficients of the 81 Items of the MCS-Thai Version 4 (N= 809)

MCS-Thai version 4	Number of items	Alpha coefficients
1. Respect patient's privacy and keeping patient's information confidential	22	.95
2. Respect for patients	25	.93
3. Providing care equally to each patient	9	.91
4. Causing no harm to patients	12	.90
5. Doing good for patients	8	.88
6. Telling the truth to patients and healthcare team	5	.84
Total	81	.98

Step 4: Final testing for construct validity and stability reliability

Final testing was performed to examine construct validity of the MCS-Thai using hypothesis testing and examine stability reliability using test-retest method. The results are as follows:

Hypothesis testing to determine construct validity

The Nursing Professional Value Scale-Revised (NPVS-R) was evaluated for validity with 30 samples fourth year baccalaureate nursing students using Cronbach's alpha which was 0.90. Pearson's product moment correlation coefficient was used to test the proposed hypothesis "the score of MCS-Thai had a positive correlation with the score of NPVS-R." It was found that there was a moderate positive correlation between the total score of the MCS-Thai and the total scores of the NPVS-R at 0.01 level (r =.54**).

Test-retest to determine stability reliability

To test the stability of the MCS-Thai (version 4), test-retest reliability was performed. The 81-item MCS-Thai was distributed to the same group of 30 nursing students from the participating nursing school, the same procedure was then repeated. The results of the scores of six factors and the total score of the MCS-Thai for the two testing times which were evaluated for correlation by using Pearson's product moment correlation coefficient. There was a positive correlation between time 1 and time 2 (r =.77**) and statistically significant correlations ($p < .01$). The results indicated that the MCS-Thai consisting of 81 items had stability reliability.

Discussion

The purpose of this study was to develop a tool to measure moral commitment in Thai nursing students. The discussion of findings is presented in two parts which consisted of: (1) the components of the MCS-Thai, and (2) the psychometric properties of the MCS-Thai.

1. The components of the MCS-Thai

The total scale of the MCS- Thai

The results in this study which found that baccalaureate nursing students showed moral commitment to patients while providing care through their willingness, determination, intention, motivation, support, protection, and commitment for patient's best interests. Moral commitments were congruent and displayed with ethical principles comprised of respect for autonomy, nonmaleficence, beneficence, justice, veracity, and fidelity. It could be summarized that the MCS-

Thai covered the six main ethical principles which were used as a guideline for health personnel in order to provide a high standard of care to patients.

The MCS-Thai final version is composed of 81 items with 6 factors: (1) respect patient's privacy and keeping patient's information confidential, (2) respect for patients, (3) providing care equally to each patient, (4) causing no harm to patients, (5) doing good for patients, and (6) telling the truth to patients and healthcare team. The eigenvalues of all factors were all greater than 1.0, each factor ranged from 1.93-39.82 and was considered significant (Hair et al., 2010; Ho, 2014; Waltz et al., 2017). All items of MCS-Thai were composed of high factor loadings ranged from 0.45-0.68 which indicated all items have a high level to interpret the structure, and correlation among the items and also between the items and the factors were achieved (Hair et al., 2010; Waltz et al., 2017). The overall internal consistency of MCS-Thai 81 items was .98 and ranged from .84-.95 for each factor which indicated high reliability. According to Polit & Beck (2018), internal consistency of each factor and the total scale at equal or greater than .70 usually indicates the accuracy of the measure. The total percent variance explained by the six factors was 47.7%. The same finding was observed in studies by Brasileiro et al. (2016) and Scherer, Weibe, Luther, and Adams (1988), which claimed that a variance between 40% and 50% is considered sufficient in social science. Moreover, some indicated that as little as 50% of the variance explained is acceptable (Beavers, Lounsbury, Richards, Huck, Skolits, & Esquivel, 2013). Therefore, the total percent of variance explained was adequate for a newly developed instrument. In conclusion, the MCS-Thai is suitable tool to evaluate moral commitment for Thai baccalaureate nursing students.

The six factors of the MCS- Thai

Factor I: Respect patient's privacy and keeping patient's information confidential

The first factor consisted of 22 items with factor loadings ranging from 0.50-0.68. The factor was labeled "Respect patient's privacy and keeping patient's information confidential" because the item content reflected nursing students preservation of patients' confidentiality and their concern for patients' privacy while using high technology or social media which can effect patients and family.

The first factor had a high percent of variance (11.43%) with an eigen value of 39.82 as nursing students in this study reflected extreme concern for patients' privacy and confidentiality. According to Westrick (2016), negative outcomes of social media misuse influenced the nursing profession. Previous legal cases have been utilized by the nursing profession in order to supply further instruction to nursing students. In regard to the nursing profession, multiple issues have emerged through use of electronic communication and social media including inadequate privacy settings to safeguard communication, lack of control over information sent to others or posted on websites, the continued existence of deleted material with indefinite access, and lack of consideration regarding information sharing in a multitude of situations. Examples of items were stated in item 15 "I will not mention a patient's name or patient's information in public," item 21 "I will not post a patient's photograph online," and item 5 "I will not reveal patient's information to others without the patient's permission." The results were consistent with Pessalacia, Tavares, de Faria, Oliveira, and de Souza (2013) who stated that

nursing students stressed the requirement for screen use in data collection in order to maintain the privacy of patients and carried out the data collection process with the intention of safeguarding patients' privacy. In addition, Kim and An (2017) noted that nursing students experienced regret concerning the uploading of information of an impersonal and sensitive nature online in relation to invasion of privacy. Nursing students acknowledged the human need for privacy as a critical concept in the ethics of nursing and healthcare. Furthermore, Zangão and Mendes (2015) stated that the attitude and posture of senior nursing students exhibited higher contact skill in the preserving of patients' privacy as the positioned themselves in front of patients.

The nursing students in this study perceived their moral duty to keep patient's information confidential as reflected in item 1 "I will carefully keep a patient's confidentiality during nursing care conferences," item 6 "I will carefully keep patient's details confidential while reporting information to the next shift," item 12 "I will always ask what information that patient wants to keep confidential," and item 14 "I will keep a patient's private information confidential." Confidentiality is an integral component of the patient and healthcare provider relationship. Confidential information is given by nurses and other healthcare providers. Some information is clearly confidential such as patient's condition and diagnosis. Thus, the relationship could be destroyed if patients' information is disclosed by the nurse who was expected to keep it secret (Rumbold, 1986). The nature of confidentiality is particularly connected to protecting a person's information, more specifically their healthcare information (Grace, 2014). Patients truly expected that it is a professional obligation of health care personnel to keep their information confidential (Tarkel & Duval, 1999). Instances of nursing situations requiring protection of confidentiality

include healthcare information, records, and personal information of patients. Furthermore, preserving information confidentiality offers health care providers protection against unsanctioned dispensation of information and resulting legal and ethical disputes (Westrick, 2014).

However, patient's information can transfer to other health care teams or proper treatment. Example items were 19 "I will give patient's information to the health care team for medical treatment and nursing care," item 7 "I will not expose a patient's illness information to the others, besides health care members," item 2 "I will keep a patient's secret if it will not harm others," and item 5 "I will not reveal patient's information to others without the patient's permission." The results were in accordance with Finkelman & Kenner (2013) who stated that nurses must remember that patient's information is private and should not be discussed in public areas or any place. According to Beauchamp & Childress (2013), confidentiality is infringed when one person discloses information to another or deliberately disclosed without the first party consent. Moreover, the patient has the right to expect that his/her diagnosis is confidential information. Nursing students in this study also concerning patient's information as the statement in item 3 "I will keep information confidential while recording a patient's details," item 9 "I will keep a patient's documents in a safe place," and item 13 "I will not use a private telephone while talking about the personal information of patient." This is congruent with the study by Paavilainen et al. (2014) showed that it was important to keep patient's information in a safe place where others cannot access it. The data are kept in locked files should also be limited to a minimum number of authorized persons. According to Westrick (2014), the patient has the right to expect that the nurse will guard against any unwarranted or

unethical release of information about the patient. Thus, nursing students should carefully consider the confidentiality of each patient's information and maintain it in order to keep patient's faith from their moral commitment (Fry & Johnstone, 2008).

Since high technology has been changing the world and social media has a vital role in world wide communication, patient's information should be kept in a safety zone in order to protect its privacy. Nursing students have moral commitment to respect patient's privacy as reflected in item 22 "I will not interfere with a patient's privacy unless it is related to their health." According to Fry and Johnstone (2008), the principle of privacy is primarily concerned with the information and the conditions under which certain information that has been collected is shared. This statement is consistent with Grace (2014) who mentioned that privacy is the concept which including the right of a person to feel free from others' interference and freedom to allow or withhold access to oneself information.

Besides respect patient's privacy through not disclosing their information, nursing students in this study also provided statements concerning respect of patient's privacy while providing care as stated in item 17 "I will be careful not to expose the patient's body while providing care," and item 18 "I will expose only the part of the patient that I am providing care for." According to Grace (2014), the privacy principle means patients have the right to decide who is allowed access to their bodies for health assessment and treatment. Patients should have the right to be free from the interference of others. Inevitably, the obligation to protect the privacy of another is a basic ethical principle and a foundation of both medical and nursing ethics (Marquis & Huston, 2012).

Factor II: Respect for patients

The second factor encompassed 25 items with factor loadings ranging from 0.46-0.63. The items of MCS-Thai in this factor showed moral commitment of nursing students regarding providing information, respect for patient decisions based on their values/ beliefs/ needs, and enhancing family members to cooperate in the health care.

Providing information to patients is an obligation of nurses. Nursing students in this study felt committed to giving essential information to the patients until they clearly understood as demonstrated in item 10 “I will give information to the patients until it matches their needs,” item 11 “Whenever I give information to patients, I have to reassess whether they can understand very well,” and item 23 “I am pleased to provide repeated information until it is clearly understood by the patient.” According to Bastable, (2014), the nurse’s role in informing the patient about their health both within and outside the healthcare organization is displayed as respect for patient. This statement was consistent with Grace (2014) who proposed that the function of the health care professional is to demonstrate responsibility in appraising the person’s information needs and helping the person in interpretation of the knowledge available concerning the plans and desires of each patient. Moreover, nursing students in this study demonstrated moral commitment to respect patients through looking for additional resources to enhance patients by making decisions, as stated in item 17 “I try to seek health information from reliable resources to assist patients.” Similarly, Pessalacia et al. (2013) declared that nursing students demonstrated their respect for patients through supplying information facilitating patients to make informed choices on nursing care. Providing information to patients

prior to collection of data has also been noted as helping both patients and nursing students to relax. This was supported by Moser et al. (2009) who found that specialist nurses were committed to providing information and giving freedom of choice to patients with diabetes, enhancing sharing of ideas and making decisions to maintain a good relationship between nurses and patients even if they did not required for care at that time. It could be noted that nurses perform a vital role before a patient makes a decision, through covering and conveying the necessary factual information which emerges in each step of nursing care.

Besides, in the views of healthcare professionals, providing information to each patient is a moral commitment showing respect for patients. Respect for patient's decision making based on their values, beliefs and needs should also be considered in order to demonstrate respect for patients. All patients have their own rights for autonomous decision making without coercion or interruptions from others involved in situations. Even though, nurses may disagree with patient's ideas or choices or wants, nurses should accept and respect their decision as if they were an autonomous agent. Nurses and other healthcare members must nurture patient's decision making following their values, beliefs and needs supported by respect for autonomy, human rights, and the constitution. Nursing students in this study showed moral commitment to respect patients based on their values, beliefs and needs, as stated in item 1 "I will provide care according to a patient's values and beliefs," item 15 "I intend to help patients to make decisions consistent with their values and beliefs," item 7 "I will promote patient's actions according to religious beliefs, if it does not violate others," and item 24 "I will not try to use my ideas or beliefs to judge patients' thoughts or behaviors." According to Bandman & Bandman (1995),

"patients are entitled to accept or reject interventions on the basis of their personal values or own goals." The nurse permits the patient to preserve their individuality, beliefs, and differentness, despite the nurse's individual values (Westrick, 2014).

Moral commitment of nurses in order to respect patients can reflect the listening and openness of nurses while in discussion with patients in actual situations (Cusveller & Schep-Akkerman, 2016). In this study, nursing students were determined to respect patients throughout listening and kept an open mind as stated in item 9 "I will promptly listen to patients' complaints and/or their questions," and item 13 "I am ready to accept if a patient refuses my suggestions." These findings were supported by the study of Dobrowolskai et al. (2014) which found that medical and nursing students used listening and communication skills with patients that were vital in being able to answer patients' questions and explore their uncertainty concerning any problems or their illness.

Commitment to respect for a patient is involved with competence in decision making and the right to make decisions. Nurses and other healthcare teams should be concerned that patients have a freedom of choice (Faghanipour et al., 2013; Marquis & Huston, 2012). Since providing information is an important step before making decisions, nurses should always be beside patients while providing care and giving information to them as they wish. The items concerning the moral commitments of nursing students in providing information were item 2 "I will help patients to make autonomous decisions as they wish," item 3 "I intend to help patients to take action after they make decisions," item 8 "I am ready to accept the different ideas of patients if they are conscious and authorized in making decisions," and item 20 "Even though I disagree about patient's decisions, I will let him/her

make decisions." Respect for others is a significant concept based on human rights. It is consistent with the ethical principle of respect for patient's autonomy which emphasizes on the patient's right to make decisions about details that impact on them (Finkelman & Kenner, 2013). Autonomy is encouraged and used in decisions and interventions that are planned to assist a patient to make informed treatment choices while free from the controlling interferences of others (Bastable, 2014; McGonigle & Mastrian, 2015).

The nurse's role is to provide information to ensure that the patient receives the information and support the patient's decision in regards to their health (Bandman & Bandman, 1995; Finkelman & Kenner, 2013). Patients were informed of their rights by nurses in the healthcare setting which supported nurses' responsibilities in patient's decision making (Cowden & Moorhead, 2011). The items involved with making informed consent before patient's treatment of nursing students were item 10 "I will give information to the patients until it matches their needs," and item 11 "Whenever I give information to patients, I have to reassess whether they can understand very well." Patients have the right to informed consent based on an honest and meaningful process, however, those patients have to be able to understand the information that is provided by nurse (Rumbold, 1986). The findings of this study are similar to the informed consent issues were highlighted by Faghanipour et al. (2013) who conducted a descriptive research study in 7 hospitals with 300 patients who encountered critical situations with surgery. The highest scores belonged to the risk of rejecting surgery followed by the characteristics of the disease. The lowest scores belonged to type of anesthesia and the process of follow up.

In the case of patients who cannot make decision by themselves due to their illness or maturity, such as pediatric patient age under 18, psychiatric patient, or coma, healthcare providers have to consider someone who is authorized to make decisions for the patient. In the Thai context, patients' families are the key persons while the patient is admitted to hospital, and encouraging the family to make decisions in the patient's best interest is an inevitable issue. Example items of making decisions by patient's families were item 21 "I try to enhance family members to collaborate with health care team," and item 22 "I will cooperate with family members to search for a proxy person who can make decisions for the patient." This is supported by the study of Osterlind et al. (2016) which showed that first year nursing students enhanced patient's families in order to make decisions for dying people at the end-of-life, as they continued to commit to being respectful to patients.

Factor III: Providing care equally to each patient

Providing care equally to each patient contained 9 items with factor loadings ranging from 0.47- 0.65. This factor comprised item content regarding giving care without bias following standards of nursing care to all patients, and providing care to patients without discrimination.

Giving care without bias following standards of nursing care to all patients included the following example items 2 "I will honor all patients equally," item 1 "I will provide care to all patients with the same nursing standards," item 3 "I will help all patients under my care receive equal rights," and item 4 "I will try my best to help all patients to be treated equally." Justice is viewed as the fairness and

the equitable distribution of goods and services of the situation based on universal rules and impartiality. This principle entails ensuring equality for all individuals in regard to goods, services, and protection (Bastable, 2014; Cannon & Boswell, 2012; Haahr et al., 2014). According to Beauchamp & Childress (2013), fairness has been used to explain justice which is interpreted as fair, equitable, and appropriate treatment. Standards of justice are needed whenever a person expects benefits or burdens because of their circumstances. Inevitably, in the nursing profession, even if resources are difficult to distribute, equal treatment for all patients has to be determined before making decisions (Bandman & Bandman, 1995). Moral commitment in the form of fairness is the issue that is related to events in which moral standards and professional codes of conduct prescribe different actions (Jones & Gautschi, 1992). This is also supported by Tarkel & Duval (1999) mentioned to fairness as the right balance of interests without regard to own feelings or preferring to any side. This ensures that people receive what is due to them and no less.

Providing care to patients without discrimination is an important role of nurses and other healthcare providers including nursing students. In this study nursing students reflected moral commitment to provide care without discrimination such as in item 5 “I will treat all patients equally, regardless of educational level or social status,” item 7 “I will provide care to patients of different races or religions without bias,” and item 9 “I will not discriminate in the care of a patient, even if they have a different opinion or belief.” This was in accordance with Myhrvold (2015), who proposed that health professionals, whether through the overall standard of healthcare or social welfare can contribute to sufficiently fulfilling their duty without discrimination, which is important within the ethics of care. Inevitably, the nurses

have to provide care to all patients fairly without regard to personal characteristics, socioeconomic status, or the health problems (Westrick, 2014). The sense of providing care equally is about the commitment to patient care which is supported by evidence based on Choe et al. (2013) pointed out the principles of justice, in particular, women violations. In addition to nurse educators, nursing students in Korea are also important persons in safeguarding equality in society. Nurse educators and students should take a leading role in supporting and advocating for AIDS patients in order to provide equity of care.

Factor IV: Causing no harm to patients

This factor comprised of 12 items with factor loadings ranging from 0.45- 0.58. These items are concerned with doing no harm to patients including pain and suffering, and emotional harm.

Nursing students in this study reflected moral commitment to do no harm to patients through providing care without causing pain and suffering as reflected in item 5 “I am determined not to increase patients’ pain from my nursing practice,” item 7 “I will not use suction techniques that cause suffering and pain to patients,” item 6 “I will not use techniques or solutions that will cause patients’ more pain from wound dressing,” item 9 “In case of intravascular injections, I will try to find the best way to reduce irritation,” and item 12 “I will be careful while working in order to prevent patients from being harmed or disabled.” According to Beauchamp and Childress (2013), principle of nonmaleficence means the obligation not to intentionally harm others by causing pain, disability, mental harm, and death which result in suffering or risks of suffering to others. This statement corresponded

with McGonigle & Mastrian (2015) who proposed that nonmaleficence referred to an obligation of healthcare providers not to induce harm and not expand the risks of harm to patient care. Westrick (2014) claimed that nurses have a moral obligation to protect patients from harm. Actions that will cause harm or ignore the treatment of patients are not acceptable. Papastavrou, Andreou, & Vryonides (2014) found that the realization of nurses concerning the inconsistency between nurses' actions and patients' needs could create a range of negative feelings such as discomfort and suffering, leading to significant negative consequences for both nurses and patients.

Moreover, the other items also reflected moral commitment to do no harm involving emotional harm. Examples were item 1 “I will not get angry or irritated towards patients,” item 4 “Even if a patient uses aggressive words and gestures towards me, I will keep calm,” item 2 “I will not make patients feel more anxious while being admitted to hospital,” and item 8 “I will not use words or actions that make the patient feel embarrassed or inferior.” Nurses should always act as health personnel who cause no harm to the patient. Avoiding harm requires understanding the situation, which we are harming and how to avoid doing harm (Ellis, 2017). Causing no harm to others was consistent with the nonmaleficence principle which refers to the obligation not to harm others and is also significant to legal determination when negligence and/or malpractice issues are raised in all situations. The potential risk of harm to patients should be the least possible (Cannon & Boswell, 2012; Haahr et al., 2014). A patient’s suffering may also arise from treatment administered by the health care team. Healthcare providers must take responsibility for any unforeseeable harm arising from treatment. Examples of items which nursing students reflected on in this study took into the consideration the

emotional suffering of patients in accordance with Dobrowolskai et al. (2014) which pointed out that nursing students indicated the necessity for time and patience while answering patients' questions. They were also aware of their limitations and the effectiveness of approaches to minimizing patients' anxiety.

Factor V: Doing good for patients

The fifth factor incorporated 8 items with factor loadings ranging from 0.46- 0.58. The focus of this factor supported the content concerning providing high quality care and maintaining patient safety.

Nursing students in this study demonstrated moral commitment to providing high quality care for patients as reflected in item 1 "I intend to dedicate myself and time to help patients receive high quality care," item 3 "I am pleased and willing to take care of patients," item 2 "I will take care of the patient throughout the duration of time, no matter how busy the work is," item 4 "I am committed to serving patients despite sacrificing personal happiness," and item 8 "I will always cheer up the patients." These items are supported by the principle of beneficence. According to Beauchamp & Childress (2013), the principle of beneficence involves the willingness to help others. This principle refers to a moral obligation to provide good such as kindness, love, and action to benefit other persons. This was supported by Cannon & Boswell (2012) and Chadwick et al. (2011) who claimed that most situations are focused on actions that will bring about the greatest good or beneficial outcomes as practice with specific moral qualities for patients involved in each situation.

In a healthcare setting, the beneficence principle is related to caring for patients. Nursing students in this study also reflected caring as stated in item 7 “I will reveal understanding and concern to the patient,” and item 5 “I am ready to assist patients without being asked.” These items were in accordance with the findings by Kapborg & Berterö (2003) which showed the phenomenon of caring from a novice student nurse’s perspective. Three categories of caring were identified as doing, being, and taking a professional role. According to Beauchamp & Childress (2013), one of nurse’s fundamental obligations is reassurance of patient’s feelings, being sympathetic and being present as a caring and knowledgeable professional. This is supported by Dobrowolskai et al. (2014) who pointed out that nursing students made an effort in helping, were interested in the condition of patients, worried about their patients, and were with their patients.

Maintaining patient safety was reflected in this factor. The nursing students in this study tended to provide good nursing care to patients and assured that their patients were safe after a procedure or medical treatment, as reflected in item 6 “I will take care of patients until I am sure that the patient is safe after medication is given.” Results supported that nurses have a moral obligation to do good, and the patient has a right to safe care. Quality improvement is determined by the consequences of patient safety and good quality outcomes of caring (Arries, 2014; Bastable, 2014). According to Grace (2014), caring is an important concept which could be described as focused attention on patient and engagement with the patient to determine personal needs and use of clinical judgment to meet those needs. Wilk & Bowllan (2011) found that nursing students maintained patient safety as a priority in clinical performance behaviors. In the case of nurses, beneficence is viewed as a duty

to maximize benefits to patients while engaging in the role of healthcare providers (Finkelman & Kenner, 2013; Grace, 2014). Such a duty, as a healthcare practitioner has a legal, moral, and professional obligation to serve the best interests of patients. Nurses also have obligations to protect patients from any avoidable harm while providing care to patients (Avery, 2017; Fry, Veatch, & Taylor, 2011; Grace, 2014).

Factor VI: Telling the truth to patients and healthcare team

The sixth factor is composed of 5 items with factor loadings ranging from 0.46 - 0.56. This factor is concerned with providing truthful information to patients and reporting based on fact.

Nursing students in this study reflected moral commitment to provide truthful information. This was precisely found in this study in items which displayed telling the truth to patients such as item 1 “I will provide clear and truthful information about patients’ health until they understand very well.” which is supported by the principle of veracity. The principle of veracity is defined as the duty to provide the truthful information and not to lie or deceive others (Fry & Johnstone, 2008). Truthfulness in giving patients’ information about their health care needs is expected by all party players, the affected individual can use the truthful and necessary information to appropriately enhance the patient’s autonomous decision making (Cannon & Boswell, 2012; Grace, 2014; Westrick, 2014). This finding was in accordance with the study of Faghanipour et al. (2013) revealed providing information, the sufficient level of information about the disease, surgery type, the positive outcomes and reason for the surgery, and the results of rejecting medical treatments such as risks and complications. Furthermore, nursing students in this

study determined to provide truthful information through consultation with other healthcare providers as stated in item 4 “In cases where the patient needs information beyond my duties. I will coordinate with those involved in providing information to patients.” According to Rumbold (1986), truth telling is a good thing if we accept the notion that patients have a right to know their information, treatment, and prognosis. Healthcare teams have an obligation to provide that information. Without the truth, the patient cannot make an informed judgment based on reason. Therefore, nurses and the collaborative team should offer more information or ways to be involved in the decision making process. This is supported by Cherry & Jacob (2017) who stated that one of the best healthcare as a result of the exchange between the patient and healthcare providers which concerning patient’s needs and healthcare provider’s judgment using open communication. Telling the truth is always right and reflected as a moral requirement in personal communication.

Reporting based on fact is an important aspect of telling the truth. In this study, it is reflected in item 5 “I will write a nursing report on what I have done,” and item 3 “I will report the mistakes of others.” According to Cherry & Jacob (2017), nurses must immediately act if anyone else may be putting the patient at risk, they should inform someone in authority when encountering problems. Additionally, nurses must report all concerns in writing if problems in the environment of care are putting the patient at risk. The items in this study were supported by the evidence based research of Wilk & Bowllan (2011) which found that nursing students reported any clinical/professional concerns of health care teams, were honest to report the mistake, and reported any omissions of care. Similarly, Choe et al. (2013), founding

that nursing students have an attitude of moderation to patients under care. Nursing students witnessed unethical situations particularly ethical issues that involved being more serious in critical situations.

2. The psychometrics properties of the MCS-Thai

The contents of the discussion in this part consists of three aspects: (1) the content validity of the MCS-Thai, (2) the construct validity of the MCS-Thai, and (3) the reliability of the MCS-Thai.

The content validity of the MCS-Thai

The content validity index of MCS-Thai version 1 had item-level content validity indices (I-CVIs) ranged from 0.80 to 1.00, S-CVI/UA (universal agreement) was 0.90, and S-CVI/Ave (average) was 0.92. A content validity index (CVI) after calculation indicated the standard for developing a scale's content validity (Polit & Beck, 2010). I-CVIs and S-CVI values equal or greater 0.8 are considered as achieving excellent content validity (Polit & Beck, 2006; Polit, Beck, & Owen, 2007). Therefore, the result of the CVI supported that the MCS-Thai contained satisfactory statements for a newly developed instrument designed to measure the moral commitment of Thai baccalaureate nursing students.

The construct validity of the MCS-Thai

The construct validity of the MCS-Thai was tested using EFA and hypothesis testing. The EFA came up with six factors with 81 items. Each item pool generated factor loadings more than 0.45 and revealed the name of each factor. This

result was supported by Waltz et. al. (2017) in that moderate to high factor loadings of each item pool was acceptable. This can be interpreted in the same way as correlation coefficients which expressed the correlation among the items and also between the items and the factors. Additionally, all factors had eigenvalues greater than 1 (Ho, 2014) and most of them accounted for at least 5% of variance which was adequate (Hair et al., 2010). The MCS-Thai accounted for 47.7% of total variance which was acceptable, meaning the scale captured the construct of moral commitment and was acceptable for use in evaluating moral commitment in Thai baccalaureate nursing students (Brasileiro et al., 2016; Scherer et al., 1988).

Furthermore, hypothesis testing was used to test the construct validity of the MCS-Thai. Previously, the proposed hypothesis claimed that there was a positive correlation between the moral commitment and nurse professional values of baccalaureate nursing students. The result revealed a positive correlation between two sets of data in the same group of participants ($r = .54$, $p < .01$). Thus, the positive correlation between the moral commitment and nurse professional values reflects the construct validity of the MCS-Thai.

The reliability of the MCS-Thai

To test the reliability of the MCS-Thai, Cronbach's alpha coefficient was used for determining internal consistency and the test-retest method was used for examining the stability of the scale. Cronbach's alpha coefficient was used in three steps; pre-testing, field-testing, and post-testing and results showed an alpha of .98 in each step. The alpha value higher than .70 ($\alpha = .98$) represents good internal consistency for a newly developed instrument (Nunnally & Bernstein, 1994; Polit &

Beck, 2018). It is undeniable that the results of the MCS-Thai support the reliability of the scale.

For testing stability reliability of the MCS-Thai, the researcher used the test-retest method two weeks after administration to the study sample. The result in this step demonstrated a correlation between the first and second time (r = .77, p < .01). The constant of the score inferred the reliability of the tool even though the tool had been used separately to measure on two occasions. The results inferred the statics of the scores still remained from one period of time to another and the MCS-Thai definitely reflected stability reliability because it was correlated after separate occasions of the event (DeVellis, 2017).

Summary

The MCS-Thai developed and evaluated psychometric properties using EFA with varimax rotation. The results displayed 6 factors comprising of 1) respect patient's privacy and keeping patient’s information confidential, 2) respect for patients, 3) providing care equally to each patient, 4) causing no harm to patients, 5) doing good for patients, and 6) telling the truth to patients and healthcare team. All items had high factor loadings on each factor and the total variance explained of the MCS-Thai was acceptable. To test internal consistency using Chronbach’s alpha correlation coefficient which indicated a high reliability. Construct validity using hypothesis testing supported construct validity. Stability reliability was determined using test-retest which pointed out the stability of the MCS-Thai.

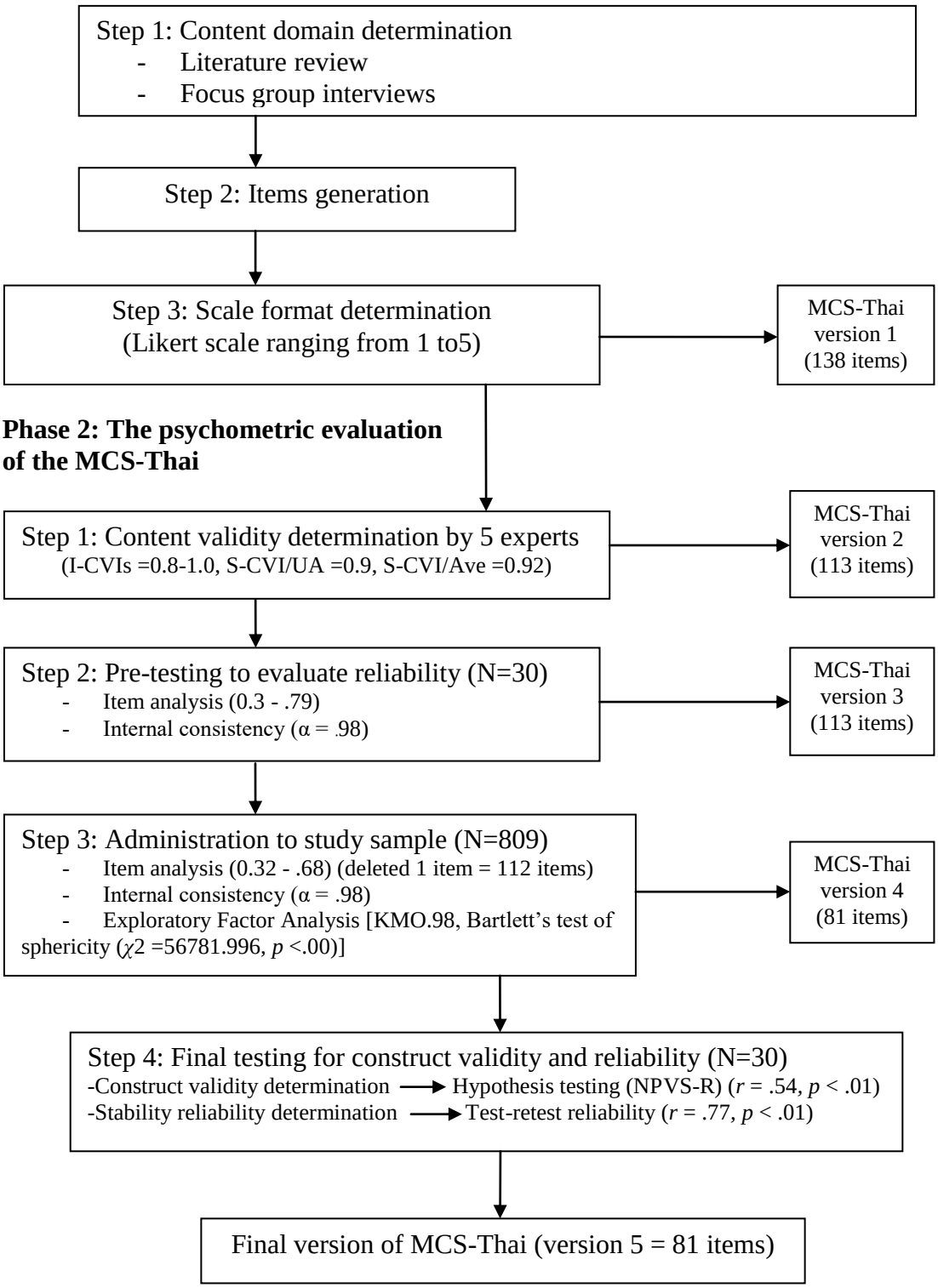

Figure 4.2 Results of steps in development and psychometric evaluation of the MCS-Thai

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents the conclusions of the study which supported the development and psychometric properties evaluation of the new instrument to determine the moral commitment for Thai nursing students. The benefits and implications of the study are analyzed. The recommendations of the findings in this study were proposed for nursing education, practice, administration, and research.

Conclusions

The purpose of this study was to develop a scale and test its psychometric properties to measure moral commitment for Thai baccalaureate nursing students.

This study consisted of 2 phases: (1) the development of moral commitment in Thai baccalaureate nursing students which comprised 113 items, (2) the evaluation of the psychometric properties of MCS-Thai. It was found that the scale had high item-level content validity indices (I-CVIs) ranging from 0.80 to 1.00, S-CVI/UA (universal agreement) was 0.90, and S-CVI/Ave (average) was 0.92.

Exploratory factor analysis using varimax rotation was conducted with 809 cases senior baccalaureate nursing students in Thailand from five regions. The results used to develop the Moral Commitment Scale for Thai nursing students

which were composed of 81 items with six factors with a total variance explained by 47.7%. Factor loadings of the MCS-Thai ranged from .45-.68. Internal consistency reliability was performed using Cronbach alpha coefficient of .98. The results of the six factors were as follows: (1) respect patient's privacy and keeping patient's information confidential, (2) respect for patients, (3) providing care equally to each patient, (4) causing no harm to patients, (5) doing good for patients, and (6) telling the truth to patients and healthcare team.

1. Factor 1: Respect patient's privacy and keeping patient's information confidential (22 items) had factor loadings ranging from 0.50-0.68 and accounted for 11.43% of variance with an eigenvalue of 39.82, and alpha coefficient of .95.

2. Factor 2: Respect for patients (25 items) had factor loadings ranging from 0.46-0.63 and accounted for 10.46% of variance with an eigenvalue of 4.86, and alpha coefficient of .93.

3. Factor 3: Providing care equally to each patient (9 items) had factor loadings ranging from 0.47-0.65 and accounted for 8.74% of variance with an eigenvalue of 2.61, and alpha coefficient of .91.

4. Factor 4: Causing no harm to patients (12 items) had factor loadings ranging from 0.45-0.58 and accounted for 5.99% of variance with an eigenvalue of 2.17, and alpha coefficient of .90.

5. Factor 5: Doing good for patients (8 items) had factor loadings ranging from 0.46-0.58 and accounted for 5.67% of variance with an eigenvalue of 2.03, and alpha coefficient of .88.

6. Factor 6: Telling the truth to patients and healthcare teams (5 items) had factor loadings ranging from 0.46-0.56 and accounted for 5.42% of variance with an eigenvalue of 1.93, and alpha coefficient of .84.

Furthermore, the construct validity using hypothesis testing was used. The result found that the hypothesis was supported by a statistically significant correlation between moral commitment and nursing professional value (r = .54, p < .01). Additionally, the stability of MCS-Thai was examined to determine the reliability of the scale using test-retest method. The result showed correlation between the scores of moral commitment evaluated twice (r = .77, p < .01). It can be concluded that the MCS-Thai has acceptable validity and reliability.

Implications and Recommendations

The MCS-Thai is a valid and reliable tool to measure moral commitment for Thai baccalaureate nursing students. The recommendations and implications are presented as follows:

Nursing education

The MCS-Thai can be used to assess moral commitment in nursing students to evaluate moral problems before nursing practice. Nurse educators can prepare learning strategies and design lesson plans for moral cultivation from the first to the fourth year of baccalaureate nursing students.

Nursing research

Researchers can use the MCS-Thai to assess moral commitment in nursing students. This scale can be used as a guideline to evaluate moral commitment which is useful in the nursing profession.

Nursing practice

The MCS-Thai can be used for the assessment of moral commitment in nursing students in different areas while practicing. Additionally, the MCS- Thai also can use to assess moral commitment in nurses. The implication of the results can emphasize the level of moral commitment when nursing students and nurses provide care in the patient's best interest.

Strengths of the study

Strengths of the MCS-Thai are as follows:

1. The MCS-Thai demonstrated the good validity and high reliability which was tested by more than one method. The construct validity was performed using exploratory factor analysis (EFA) and hypothesis testing. The reliability was performed using internal consistency and stability which supported the quality of the scale.

2. The MCS-Thai is the standard tool which was generated through the steps of scale development to measure moral commitment in Thai baccalaureate nursing students.

Limitation of the study

Even though, the MCS-Thai meet the criteria which valid and reliable instrument. A total percentage of variance by 47.7% was observed in this study, therefore, the MCS-Thai should be refined in the future with the other phenomenon for representative of the study. It is challengeable for researchers and nurse educators who are interested in moral commitment.

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Appendices

Appendix A

List of Expertise

Five experts examined the content validity of the Moral Commitment Scale. The experts are as follows:

1. Associate Professor Dr. Siriporn Khampalikit
2. Associate Professor Dr. Wandee Suttharangsee

   Faculty of Nursing, Prince of Songkla University
3. Assistant Professor Dr. Suntarawadee Theinpichet

   Continuing Nursing Education Test Center
4. Assistant Professor Dr. Kanogwan Suwanpatikorn

   Srisavarindhira Thai Red Cross Institute of Nursing
5. Dr. Rodchana Wiriyasombat

   Nurse educator, Boromarajonani Songkhla Nursing College

Appendix B

Content validity form

Appendix B

แบบประเมินความตรงตามเนื้อหา (Content Validity Form) ของเครื่องมือวิจัย

เอกสารชุดนี้เป็นแบบประเมินความตรงตามเนื้อหาของเครื่องมือวิจัย ผู้วิจัยขอความกรุณาจากท่านในการแสดงความคิดเห็นเกี่ยวกับระดับความสอดคล้องของเนื้อหา (Relevancy) โดย 4=สอดคล้องดีมาก 3=สอดคล้องดี 2=สอดคล้องเล็กน้อย 1=ไม่สอดคล้อง รวมถึงแสดงความคิดเห็นด้านความชัดเจน (Clarity) และความกระชับ (Conciseness) ของคำถาม โดยขอให้ท่านทำเครื่องหมายถูก (✓) ลงในช่องที่ตรงกับความคิดเห็นของท่านหลังคำถามแต่ละข้อ และหากข้อคำถามใดที่ท่านเห็นว่าสอดคล้องเล็กน้อย ไม่สอดคล้อง ไม่ชัดเจน หรือไม่กระชับความ สมควรแก่การปรับปรุงหรือมีข้อเสนอแนะอื่นๆกรุณาเติมข้อความในช่องแสดงข้อเสนอแนะด้วย ผู้วิจัยขอขอบคุณในความอนุเคราะห์ของท่านครั้งนี้เป็นอย่างยิ่ง

	ข้อคำถามความมุ่งมั่นทางจริยธรรม	**สอดคล้องกับวัตถุประสงค์การวิจัย**			**ความสอดคล้องกับเนื้อหาที่ต้องการวัด**					**ความชัดเจน**		**ความกระชับ**		**ข้อเสนอแนะในการปรับปรุง**
		วัตถุประสงค์ข้อที่	สอดคล้อง	ไม่สอดคล้อง	เนื้อหาที่วัด	4	3	2	1	ชัดเจน	ไม่ชัดเจน	กระชับ	ไม่กระชับ	
1.	**ด้านการเคารพผู้ป่วย (Respect for patients)** ฉันจะต้องบอกชื่อ-สกุล แก่ผู้ป่วยที่อยู่ในความดูแล ไม่ว่าผู้ป่วยจะรับรู้ได้หรือไม่ก็ตาม													
2.	.....													

Appendix C

Certificate of approval of human research ethics

เอกสารรับรองโครงการวิจัย
โดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์
สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์

รหัสรับโครงการ: 2017 NSt – Qn 012

ชื่อโครงการ: Development and Psychometric Evaluation of the Moral Commitment Scale for Thai Baccalaureate Nursing Students (MCS-Thai)

รหัสหนังสือรับรอง: PSU IRB 2017 – NSt 008

ชื่อหัวหน้าโครงการ: นางชุติมา เพิงใหญ่

หน่วยงานที่สังกัด: หลักสูตรปรัชญาดุษฎีบัณฑิต สาขาวิชาการพยาบาล (หลักสูตรนานาชาติ)
คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์

เอกสารที่รับรอง:
1. แบบเสนอโครงการเข้ารับการประเมินจริยธรรมในงานวิจัย
2. เครื่องมือวิจัย
3. ใบเชิญชวนและใบยินยอมเข้าร่วมการวิจัย

วันที่รับรอง: 24 พฤษภาคม 2560

วันที่หมดอายุ: 24 พฤษภาคม 2562

ขอรับรองว่าโครงการดังกล่าวข้างต้น ได้ผ่านการพิจารณาเห็นชอบโดยสอดคล้องกับหลักการเบลมองต์ (Belmont) จากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์

(ลงนาม).....
(รองศาสตราจารย์ ดร.อรัญญา เชาวลิต)
ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์
สาขาสังคมศาสตร์และพฤติกรรมศาสตร์ มหาวิทยาลัยสงขลานครินทร์

Appendix D

Protection of human subject's right

แบบฟอร์มพิทักษ์สิทธิผู้เข้าร่วมวิจัย

เรียน นักศึกษาพยาบาลผู้เข้าร่วมวิจัย

ดิฉัน นางชุติมา เพิงใหญ่ อาจารย์พยาบาลประจำภาควิชาการพยาบาลเด็กและวัยรุ่น วิทยาลัยพยาบาลบรมราชชนนี สงขลา กำลังศึกษาต่อในระดับปริญญาเอก สาขาการพยาบาล คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ วิทยาเขตหาดใหญ่ ขณะนี้อยู่ระหว่างการทำวิทยานิพนธ์เรื่อง การพัฒนาและการประเมินเครื่องมือวัดความมุ่งมั่นทางจริยธรรมของนักศึกษาพยาบาลศาสตรบัณฑิตของประเทศไทย (Development and Psychometric Evaluation of the Moral Commitment Scale for Thai Baccalaureate Nursing Students, MCS-Thai) โดยมี รองศาสตราจารย์ ดร. อรัญญา เชาวลิต เป็นอาจารย์ที่ปรึกษาวิทยานิพนธ์ ซึ่งงานวิจัยชิ้นนี้มีวัตถุประสงค์เพื่อสร้างเครื่องมือมาตรฐานสำหรับการประเมินความมุ่งมั่นทางจริยธรรมต่อผู้ป่วยของนักศึกษาพยาบาลไทย ซึ่งท่านจะเป็นตัวแทนนักศึกษาพยาบาลที่ยินดีเข้าร่วมการวิจัยโดยการตอบแบบสอบถามนี้

ในการที่ท่านเข้ามามีส่วนร่วมในการวิจัยครั้งนี้ เป็นความสมัครใจโดยแท้จริง เมื่อท่านเข้าร่วมโครงการวิจัยแล้ว ท่านสามารถถอนตัวจากการวิจัยได้ตลอดเวลาที่ท่านต้องการ หากท่านรู้สึกไม่สะดวกหรือมีข้อขัดข้องใดๆท่านสามารถยุติการตอบแบบสอบถามได้ทันที โดยที่ท่านจะไม่ได้รับผลกระทบใดๆทั้งต่อตัวท่านเอง ครอบครัว และการศึกษา ผลการวิจัยครั้งนี้จะไม่มีการเปิดเผยชื่อท่าน และข้อมูลที่ได้รับจากท่านจะถูกนำเสนอในภาพรวมของนักศึกษาพยาบาลเท่านั้น

หากท่านประสงค์จะสอบถามข้อสงสัยใดๆเกี่ยวกับการศึกษานี้ สามารถติดต่อดิฉันได้โดยตรงและขอขอบคุณเป็นอย่างสูงที่ท่านกรุณาให้ความร่วมมือเป็นอย่างดี

ขอแสดงความนับถือ

(นางชุติมา เพิงใหญ่)

ผู้ทำการวิจัย นางชุติมา เพิงใหญ่
เบอร์โทรศัพท์ 081-5981173 Email: chu.smile1@gmail.com

สำหรับผู้ร่วมวิจัย

ข้าพเจ้าได้ทราบรายละเอียดเกี่ยวกับการให้ข้อมูลในแบบสอบถามและสิทธิในการให้ข้อมูลข้างต้นแล้วและสมัครใจจะให้ข้อมูลเพื่อเป็นประโยชน์ต่อการศึกษาครั้งนี้

.....

ลายมือชื่อผู้เข้าร่วมวิจัย

วันที่.....เดือน.....พ.ศ.2560

Appendix E

Questionnaire of the MCS-Thai

แบบสอบถาม

แบบสอบถามความมุ่งมั่นทางจริยธรรมต่อผู้ป่วยของนักศึกษาพยาบาลไทย

ส่วนที่ 1 ข้อมูลทั่วไปของนักศึกษาพยาบาล

คำชี้แจง กรุณาเติมคำในช่องว่างหรือทำเครื่องหมาย ✓ หน้าคำตอบที่ท่านต้องการ

สถาบันการศึกษา_____

ข้อมูลส่วนบุคคล

1. อายุ _____ปี
2. เพศ

   _____ชาย_____หญิง
3. ศาสนา

   _____พุทธ

   _____อิสลาม

   _____คริสต์

   _____อื่นๆ (โปรดระบุ) _____
4. ภูมิลำเนา

   _____ภาคใต้

   _____ภาคเหนือ

   _____ภาคกลาง

   _____ภาคตะวันออก

   _____ภาคตะวันออกเฉียงเหนือ
5. ผลการเรียนเฉลี่ยสะสมครั้งล่าสุด_____
6. การได้รับรางวัลที่เกี่ยวข้องกับการมีคุณธรรมและจริยธรรม

   _____เคยได้รับ (โปรดระบุ)_____

   _____ไม่เคยได้รับ
7. ประสบการณ์การฝึกภาคปฏิบัติที่รู้สึกประทับใจ (เรียงลำดับจากมากไปน้อย)

   ลำดับที่ 1 _____

   เหตุผล_____

   ลำดับที่ 2 _____

   เหตุผล_____

ส่วนที่ 2 ความมุ่งมั่นทางจริยธรรมต่อผู้ป่วยของนักศึกษาพยาบาลไทย

คำชี้แจง: แบบสอบถามนี้มีวัตถุประสงค์เพื่อศึกษาความมุ่งมั่นทางจริยธรรมต่อผู้ป่วยของนักศึกษาพยาบาลระดับปริญญาตรี โปรดทำเครื่องหมาย ✓ลงในช่องด้านขวามือของข้อความซึ่งแสดงให้เห็นว่าท่านมีความตั้งใจ/ มุ่งมั่นว่าจะต้องกระทำเช่นนั้นมากน้อยเพียงใด โดยมีระดับคะแนนดังนี้

5 หมายถึง มีความตั้งใจ/ มุ่งมั่นมากที่สุด

4 หมายถึง มีความตั้งใจ/ มุ่งมั่นมาก

3 หมายถึง มีความตั้งใจ/ มุ่งมั่นปานกลาง

2 หมายถึง มีความตั้งใจ/ มุ่งมั่นน้อย

1 หมายถึง มีความตั้งใจ/ มุ่งมั่นน้อยมาก

ข้อที่	ความมุ่งมั่นทางจริยธรรม	คะแนน				
	ข้อความ	5	4	3	2	1
	ด้านการเคารพผู้ป่วย **(Respect for patients)**					
1.	ฉันจะต้องบอกชื่อ-สกุลของฉันแก่ผู้ป่วยที่อยู่ในความดูแล ไม่ว่าผู้ป่วยจะรับรู้ได้หรือไม่ก็ตาม					
2.	ก่อนให้ข้อมูล/คำแนะนำใดๆแก่ผู้ป่วย ฉันจะต้องประเมินจนแน่ใจว่าผู้ป่วยสามารถรับรู้และทำความเข้าใจในข้อมูล					
3.	ฉันจะให้ข้อมูลกับผู้ป่วยจนมั่นใจว่าตรงกับความต้องการของผู้ป่วย					
4.	ภายหลังให้ข้อมูลแก่ผู้ป่วยทุกครั้ง ฉันจะต้องประเมินว่าผู้ป่วยเข้าใจข้อมูลนั้นๆได้ถูกต้อง					
5.	ฉันเต็มใจที่จะให้ข้อมูลผู้ป่วยซ้ำๆเพื่อให้มั่นใจว่าผู้ป่วยเข้าใจข้อมูลอย่างชัดเจน					
6.	ฉันจะแสวงหาข้อมูลจากแหล่งที่เชื่อถือได้ทุกช่องทางเพื่อนำมาบอกเล่าให้ผู้ป่วยได้รับรู้ข้อมูลข่าวสารทางด้านสุขภาพ					
7.	ฉันจะอธิบายถึงสิ่งที่ฉันจะปฏิบัติต่อผู้ป่วยทุกครั้ง ยกเว้นกรณีฉุกเฉินเร่งด่วนเพื่อช่วยชีวิตผู้ป่วยเท่านั้น					
8.	ฉันตั้งใจที่จะช่วยให้ผู้ป่วยได้ตัดสินใจตามคุณค่า ความเชื่อของตนเอง					
9.	ฉันจะให้การดูแลที่สอดคล้องกับคุณค่าและความเชื่อของผู้ป่วย					
10.	ฉันจะส่งเสริมการกระทำของผู้ป่วยตามความเชื่อทางศาสนา หากไม่ละเมิดผู้อื่น					

ข้อที่	ความมุ่งมั่นทางจริยธรรม	คะแนน				
	ข้อความ	5	4	3	2	1
11.	ฉันจะพยายามหลีกเลี่ยงการใช้ความคิด ความเชื่อของตนเอง ไปตัดสินความคิด/การกระทำของผู้ป่วย					
12.	ฉันจะให้เวลาเพื่อรับฟังปัญหา/คำถามจากผู้ป่วยด้วยความเต็มใจ					
13.	ฉันพร้อมที่จะยอมรับหากผู้ป่วยจะปฏิเสธคำแนะนำจากฉัน					
14.	ฉันจะตอบคำถาม/ข้อสงสัยผู้ป่วยซ้ำๆเกี่ยวกับภาวะสุขภาพโดยไม่รู้สึกรำคาญ/เบื่อหน่าย					
15.	ฉันมุ่งมั่นที่จะพิทักษ์สิทธิให้กับผู้ป่วยเมื่อพบว่าผู้ป่วยกำลังถูกละเมิดสิทธิ					
16.	ฉันจะไม่ละเมิดสิทธิของผู้ป่วยไม่ว่าผู้ป่วยจะอยู่ในสภาพที่รับรู้หรือไม่ก็ตาม					
17.	ฉันมุ่งมั่นที่จะปกป้องผู้ป่วยจากการถูกผู้อื่นดูหมิ่นศักดิ์ศรี					
18.	ฉันจะช่วยให้ผู้ป่วยได้ตัดสินใจอย่างอิสระตามที่ผู้ป่วยต้องการ					
19.	ฉันมีความตั้งใจที่จะช่วยให้ผู้ป่วยได้กระทำตามที่ตัดสินใจโดยอิสระ					
20.	ฉันพร้อมที่จะยอมรับความคิดเห็นที่แตกต่างของผู้ป่วยหากผู้ป่วยมีสติสัมปชัญญะและได้ตัดสินใจโดยอิสระ					
21.	ฉันจะเคารพในความคิดและการตัดสินใจของผู้ป่วยไม่ว่าฉันจะเห็นด้วยหรือไม่ก็ตาม					
22.	แม้ฉันจะไม่เห็นด้วยกับการตัดสินใจของผู้ป่วยแต่ฉันก็จะไม่ขัดขวางการตัดสินใจของเขา					
23.	ฉันจะไม่ให้ผู้ป่วยต้องฝืนใจทำในสิ่งที่ไม่ตรงกับความต้องการ					
24.	ฉันจะให้ความสำคัญอย่างมากกับการพิทักษ์สิทธิของผู้ป่วยกลุ่มเปราะบาง เช่น เด็ก ผู้สูงอายุ และผู้ป่วยที่มีปัญหาทางจิต					
25.	ฉันจะขออนุญาตผู้ป่วยก่อนให้การพยาบาล ไม่ว่าจะเร่งรีบเพียงใดก็ตาม					
26.	ฉันจะส่งเสริมให้ครอบครัวมีส่วนร่วมในการตัดสินใจเกี่ยวกับสุขภาพของผู้ป่วย					
27.	เมื่อผู้ป่วยตัดสินใจเองไม่ได้ ฉันจะประสานกับครอบครัวเพื่อค้นหาผู้ที่มีสิทธิและสามารถตัดสินใจแทนผู้ป่วยได้					
28.	ฉันจะไม่ทำให้ผู้ป่วยทุกข์ใจเพราะคำพูดของฉัน					
29.	ฉันจะไม่มีวันทำให้ผู้ป่วยทุกข์ใจจากกิริยาท่าทางของฉันที่แสดงต่อเขา					

ข้อที่	ความมุ่งมั่นทางจริยธรรม ข้อความ	คะแนน 5	 4	 3	 2	 1
	ด้านการไม่ทำในสิ่งที่เป็นอันตรายต่อผู้ป่วย **(Do not cause harm to patients)**					
30.	ฉันจะไม่ใช้คำพูดหรือกิริยาท่าทางที่ทำให้ผู้ป่วยรู้สึกอับอายหรือด้อยศักดิ์ศรีเป็นอันขาด					
31.	ฉันจะไม่แสดงอารมณ์โกรธหรือหงุดหงิดใส่ผู้ป่วย					
32.	แม้ผู้ป่วยจะใช้คำพูดและท่าทางก้าวร้าวใส่ฉัน ฉันก็จะไม่ใช้อารมณ์ตอบโต้ผู้ป่วย					
33.	ฉันจะไม่ทำให้ผู้ป่วยรู้สึกกังวลใจเพิ่มขึ้นขณะรับการรักษาในโรงพยาบาล					
34.	ฉันตั้งใจอย่างแน่วแน่ที่จะไม่เพิ่มความเจ็บปวดของผู้ป่วยจากการปฏิบัติการพยาบาลของฉัน					
35.	ในกลุ่มเปราะบาง เช่น ผู้ป่วยเอดส์ ผู้ป่วยมะเร็ง ผู้ป่วยระยะสุดท้าย ฯลฯ ฉันจะไม่ใช้คำพูดที่ทำให้เขาสะเทือนใจหรือน้อยใจ					
36.	ฉันจะปฏิบัติงานด้วยความไม่ประมาทเพื่อไม่ให้ผู้ป่วยเกิดอันตรายหรือพิการ					
37.	ฉันจะไม่ทำให้ผู้ป่วยได้รับเชื้อจากการปฏิบัติการพยาบาลของฉัน					
38.	ฉันจะไม่ทำให้ผู้ป่วยบาดเจ็บหรือพิการจากการกระทำของฉัน					
39.	ฉันมุ่งมั่นที่จะศึกษาหาวิธีการดูแลที่ไม่ทำให้ผู้ป่วยเจ็บปวดจากการปฏิบัติกิจกรรมการพยาบาล					
40.	ในการให้ยาที่ระคายเคืองหลอดเลือด ฉันจะพยายามหาวิธีที่ดีสุดเพื่อไม่ให้ผู้ป่วยเจ็บปวด					
41.	ฉันจะไม่ใช้วิธีการดูดเสมหะที่ทำให้ผู้ป่วยเจ็บปวดทุกข์ทรมาน					
42.	ฉันจะไม่ใช้วิธีการหรือน้ำยาที่ทำให้ผู้ป่วยเจ็บปวดมากขึ้นจากการทำแผล					
43.	ฉันจะไม่ปล่อยให้ผู้ป่วยนอนกับที่นานๆจนเกิดแผลกดทับ					
44.	หากจำเป็นต้องผูกยึด ฉันจะป้องกันหรือระมัดระวังไม่ให้ผู้ป่วยได้รับอันตรายจากการผูกยึด					
45.	ฉันจะทบทวนคำสั่งการรักษาที่คาดว่าอาจก่อให้เกิดอันตรายต่อผู้ป่วย					
46.	ฉันจะไม่ทำตามคำขอของผู้อื่น ที่อาจทำให้ผู้ป่วยได้รับอันตราย แม้ฉันจะต้องขัดแย้งกับผู้อื่นก็ตาม					

ข้อที่	ความมุ่งมั่นทางจริยธรรม	คะแนน				
	ข้อความ	5	4	3	2	1
	ด้านการทำในสิ่งที่ดีสำหรับผู้ป่วย **(Do good for patients)**					
47.	ฉันมุ่งมั่นที่จะทำประโยชน์ให้กับผู้ป่วยแม้จะต้องเสียสละความสุขส่วนตัว					
48.	ฉันตั้งใจที่จะอุทิศตนและเวลาเพื่อช่วยให้ผู้ป่วยได้รับการดูแลที่มีคุณภาพสูง					
49.	ฉันรู้สึกยินดีและเต็มใจที่ได้ดูแลช่วยเหลือผู้ป่วย					
50.	ฉันจะดูแลเอาใจใส่ใจผู้ป่วยตลอดระยะเวลาของการปฏิบัติงานไม่ว่างานจะยุ่งเพียงใด					
51.	ฉันจะคอยเป็นกำลังใจให้กับผู้ป่วย					
52.	ฉันพร้อมที่จะให้การช่วยเหลือผู้ป่วยโดยไม่ต้องให้ร้องขอ					
53.	ฉันจะแสดงให้ผู้ป่วยรับรู้ถึงความเข้าใจและความห่วงใยที่ฉันมีต่อเขา					
54.	ฉันจะให้การพยาบาลผู้ป่วยตามมาตรฐานวิชาชีพเต็มศักยภาพของฉัน					
55.	ฉันจะตรวจสอบให้มั่นใจว่าผู้ป่วยได้รับยาถูกต้องตามหลักการ					
56.	ฉันจะดูแลผู้ป่วยจนมั่นใจว่าผู้ป่วยปลอดภัยภายหลังจากที่ฉันให้ยา					
57.	ฉันจะพยายามป้องกันไม่ให้ผู้ป่วยเกิดภาวะแทรกซ้อนจากการพยาบาล					
58.	ฉันจะให้การพยาบาลที่ดีที่สุดแก่ผู้ป่วยภายใต้บทบาทอิสระของวิชาชีพ					
59.	ฉันจะให้การดูแลเพื่อส่งเสริมภาวะสุขภาพและบรรเทาอาการเจ็บป่วย					
60.	ฉันจะดูแลช่วยเหลือให้ผู้ป่วยได้รับการตอบสนองความต้องการพื้นฐาน					
61.	ฉันจะตอบสนองความต้องการของผู้ป่วยอย่างเพียงพอและเหมาะสม					
62.	ฉันจะให้ความรู้แก่ผู้ป่วยในการป้องกันโรคและความเจ็บป่วย					
63.	ฉันจะช่วยบรรเทาความเจ็บปวดทุกข์ทรมานของผู้ป่วย					
64.	ฉันจะใช้คำพูดที่สุภาพและเป็นมิตรต่อผู้ป่วย					
65.	ฉันจะให้การดูแลผู้ป่วยด้วยความนุ่มนวล อ่อนโยน					
	ด้านการไม่เลือกปฏิบัติต่อผู้ป่วย **(Provide care equally to each patient)**					
66.	ฉันจะให้การดูแลผู้ป่วยทุกรายอย่างเท่าเทียมกันโดยไม่คำนึงถึงระดับการศึกษาหรือสถานะทางสังคม					
67.	ฉันจะให้การดูแลผู้ป่วยที่มีเชื้อชาติหรือนับถือศาสนาต่างจากฉันโดยปราศจากอคติใดๆ					

ข้อที่	ความมุ่งมั่นทางจริยธรรม	คะแนน				
	ข้อความ	5	4	3	2	1
68.	ฉันจะไม่รังเกียจเมื่อต้องดูแลผู้ป่วยที่ถูกสังคมตีตรา เช่น ผู้ป่วยเอดส์ ผู้ป่วยคดี					
69.	ฉันจะไม่เลือกปฏิบัติในการดูแลผู้ป่วยแม้ว่าเขาจะมีความคิดเห็นหรือมีความเชื่อที่แตกต่างจากฉัน					
70.	แม้ผู้ป่วยจะแสดงอารมณ์โกรธหรือหงุดหงิดใส่ฉัน ฉันก็จะให้การดูแลเขาเช่นเดียวกับผู้ป่วยรายอื่นๆ					
71.	ฉันจะให้เกียรติผู้ป่วยทุกคนอย่างเท่าเทียมกัน					
72.	ฉันจะให้การดูแลผู้ป่วยทุกคนด้วยมาตรฐานการพยาบาลเดียวกัน					
73.	ฉันจะช่วยให้ผู้ป่วยทุกคนภายใต้การดูแลของฉันได้รับสิทธิอย่างเท่าเทียมกัน					
74.	ฉันจะพยายามอย่างเต็มที่ที่จะช่วยให้ผู้ป่วยทุกคนได้รับการดูแลอย่างเสมอภาค					
75.	ฉันจะต้องปรับการดูแลให้เหมาะสมกับผู้ป่วยแต่ละราย					
76.	ฉันจะให้การดูแลและช่วยเหลือผู้ป่วยตามระดับความรุนแรงของปัญหา					
77.	ฉันจะดูแลให้ผู้ป่วยที่ปฏิเสธการเข้าร่วมวิจัยได้รับการดูแลที่มีคุณภาพเช่นเดียวกับผู้ป่วยรายอื่นๆ					
78.	แม้ผู้ป่วยจะอยู่ในระยะสุดท้าย แต่ฉันก็จะให้การดูแลเขาอย่างเต็มที่เช่นเดียวกับผู้ป่วยรายอื่น					
79.	ฉันจะแสดงให้ผู้ป่วยที่สังคมรังเกียจมั่นใจว่าเขาจะได้รับการดูแลเช่นเดียวกับผู้ป่วยรายอื่นๆ					
80.	**ด้านการพูดความจริงและซื่อสัตย์ต่อผู้ป่วย** **(Tell the truth and honest with patients)** ฉันจะให้ข้อมูลผู้ป่วยตามความเป็นจริง ตามขอบเขตที่ฉันสามารถกระทำได้					
81.	ฉันจะรายงานและให้ข้อมูลที่เป็นจริงเท่านั้นต่ออาจารย์/พยาบาล/แพทย์เจ้าของไข้					
82.	ฉันจะเขียนบันทึกทางการพยาบาลในสิ่งที่ฉันได้สังเกตเห็น/กระทำจริงเท่านั้น					

ข้อที่	ความมุ่งมั่นทางจริยธรรม ข้อความ	คะแนน 5	 4	 3	 2	 1
83.	ฉันจะต้องประเมินความสามารถของผู้ป่วยในการยอมรับความจริงที่เป็นข่าวร้าย					
84.	ฉันจะต้องบอกความจริงเกี่ยวกับสุขภาพอย่างชัดเจนครบถ้วนจนมั่นใจว่าผู้ป่วยเข้าใจอย่างดี					
85.	กรณีที่ผู้ป่วยต้องการข้อมูลที่เกินขอบเขตหน้าที่ของฉัน ฉันจะประสานกับผู้ที่เกี่ยวข้องในการให้ข้อมูลแก่ผู้ป่วย					
86.	ฉันจะรายงานอาจารย์/หัวหน้าเวรทันทีเมื่อฉันได้ปฏิบัติการพยาบาลผิดพลาด					
87.	ฉันจะรายงานความผิดพลาดของตัวเองตามความเป็นจริง					
88.	ฉันจะรายงานความผิดพลาดของผู้อื่นตามความเป็นจริง					
89.	ฉันจะยอมรับความผิดพลาดของตนเองแม้จะถูกลงโทษ/ตำหนิ					
90.	ฉันมุ่งมั่นที่จะแสดงออกถึงการกระทำและคำพูดที่ทำให้ผู้ป่วยเกิดความไว้วางใจ					
91.	ฉันจะรักษาคำพูดหรือสัญญาที่ให้ไว้กับผู้ป่วยอย่างเคร่งครัด					
	ด้านการเคารพความเป็นส่วนตัวและการรักษาความลับ **(Respect patient's privacy and keep secret)**					
92.	ฉันจะไม่ก้าวก่ายเรื่องส่วนตัวที่ไม่มีผลต่อการดูแลสุขภาพของผู้ป่วย					
93.	ฉันจะไม่เอ่ยชื่อผู้ป่วยหรือกล่าวพาดพิงถึงผู้ป่วยเมื่ออยู่ในที่สาธารณะ					
94.	ฉันจะเก็บรักษาข้อมูลส่วนตัวของผู้ป่วยไว้เป็นความลับ					
95.	ฉันจะเก็บหรือวางเอกสารส่วนตัวของผู้ป่วยไว้ในที่ที่บุคคลภายนอกไม่สามารถเข้าถึงได้					
96.	ฉันจะออกจากระบบทุกครั้งเมื่อเสร็จสิ้นการสืบค้นข้อมูลผู้ป่วยด้วยคอมพิวเตอร์					
97.	ฉันจะเปิดเผยข้อมูลของผู้ป่วยแก่ทีมสุขภาพเพื่อนำไปใช้ในการรักษาพยาบาลเท่านั้น					
98.	ฉันจะไม่เปิดเผยข้อมูลเกี่ยวกับความเจ็บป่วยของผู้ป่วยต่อผู้ที่ไม่เกี่ยวข้อง					
99.	ฉันจะไม่ให้ผู้อื่นรู้ข้อมูลของผู้ป่วยก่อนที่จะได้รับอนุญาตจากผู้ป่วย					
100.	ฉันตั้งใจที่จะเก็บรักษาความลับของผู้ป่วยที่ได้ฟังมาโดยไม่ไปบอกต่อคนอื่นๆ					

ข้อที่	ความมุ่งมั่นทางจริยธรรม	คะแนน				
	ข้อความ	5	4	3	2	1
101.	ฉันจะรักษาความลับของผู้ป่วยไว้เป็นอย่างดีหากข้อมูลนั้นไม่ก่อให้เกิดอันตรายแก่บุคคลอื่น					
102.	ฉันจะระมัดระวังการเปิดเผยความลับของผู้ป่วยขณะรับ-ส่งเวร					
103.	ฉันจะระมัดระวังการเปิดเผยความลับของผู้ป่วยขณะมีการประชุมปรึกษาทางการพยาบาล					
104.	ฉันจะใช้ความรอบคอบในการบันทึกข้อมูลที่เป็นความลับของผู้ป่วย					
105.	ฉันจะไม่พูดโทรศัพท์ขณะพูดคุยเกี่ยวกับข้อมูลที่เป็นความลับของผู้ป่วย					
106.	ฉันจะไม่นำเสนอข้อมูลของผู้ป่วยก่อนที่จะได้รับอนุญาตจากผู้ป่วยโดยเด็ดขาด					
107.	ฉันจะสอบถามผู้ป่วยว่าข้อมูลใดที่ต้องการให้ปกปิด					
108.	ฉันจะสอบถามผู้ป่วยถึงบุคคลที่ผู้ป่วยยินยอมให้รับรู้ข้อมูลที่เป็นความลับของผู้ป่วยได้					
109.	ฉันจะระมัดระวังในการเปิดเผยร่างกายผู้ป่วยขณะให้การพยาบาล					
110.	ฉันจะเปิดเผยเฉพาะส่วนที่จำเป็นของร่างกายผู้ป่วยขณะให้การพยาบาล					
111.	ฉันจะไม่นำข้อมูลของผู้ป่วยเสนอทางสื่อออนไลน์					
112.	ฉันจะไม่ถ่ายภาพของผู้ป่วยเผยแพร่ทางสื่อออนไลน์					
113.	หากฉันต้องนำเสนอภาพของผู้ป่วยเพื่อนำมาใช้ในการศึกษา ฉันจะมีการปกปิดใบหน้าและชื่อของผู้ป่วย					

Appendix F

Letter of Permission to use NPVS-R

10-11-2017

Dear Mrs. Perngyai,

Thank you for your interest in our work on professional values.

An abstract, as well as The Nurses Professional Values Scale (NPVS-R) are enclosed. You have our permission to use the NPVS-R in your proposed research. We are requesting persons who use the NPVS-R to provide the following at the completion of the research:

An abstract of your research findings using the NPVS-R which includes a description of the sample.

Our most recent publication regarding the NPVS-R can be found in the *Journal of Nursing Measurement*:

Weis, D., & Schank, M.J. (2009). Development and Psychometric Evaluation of the Nurses Professional Values Scale—Revised. Journal of Nursing Measurement, 17(3), 221-231.

Best wishes for success with your research.

Sincerely,

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DW/MJS:bja

Enclosures (3)

Appendix G

Questionnaire of NPVS-R (Original version)

Nurses Professional Values Scale-R ©

Indicate the importance of the following value statements relative to nursing practice. Please circle the degree of importance.

(A = not important to E = most important) for each statement.

		Not Important	Somewhat Important	Important	Very Important	Most Important
		A	B	C	D	E
1.	Engage in on-going self-evaluation.	A	B	C	D	E
2.	Request consultation/collaboration when unable to meet patient needs.	A	B	C	D	E
3.	Protect health and safety of the public.	A	B	C	D	E
4.	Participate in public policy decisions affecting distribution of resources.	A	B	C	D	E
5.	Participate in peer review.	A	B	C	D	E
6.	Establish standards as a guide for practice.	A	B	C	D	E
7.	Promote and maintain standards where planned learning activities for students take place.	A	B	C	D	E
8.	Initiate actions to improve environments of practice.	A	B	C	D	E
9.	Seek additional education to update knowledge and skills.	A	B	C	D	E
10.	Advance the profession through active involvement in health related activities.	A	B	C	D	E
11.	Recognize role of professional nursing associations in shaping health care policy.	A	B	C	D	E
12.	Promote equitable access to nursing and health care.	A	B	C	D	E
13.	Assume responsibility for meeting health needs of the culturally diverse population.	A	B	C	D	E
14.	Accept responsibility and accountability for own practice.	A	B	C	D	E
15.	Maintain competency in area of practice.	A	B	C	D	E
16.	Protect moral and legal rights of patients.	A	B	C	D	E
17.	Refuse to participate in care if in ethical opposition to own professional values.	A	B	C	D	E

Nurses Professional Value Scale-R ©

		Not Important	Somewhat Important		Very Important	Most Important
		A	B	C	D	E
18.	Act as a patient advocate.	A	B	C	D	E
19.	Participate in nursing research and/or implement research findings appropriate to practice.	A	B	C	D	E
20.	Provide care without prejudice to patients of varying lifestyles.	A	B	C	D	E
21.	Safeguard patient's right to privacy.	A	B	C	D	E
22.	Confront practitioners with questionable or inappropriate practice.	A	B	C	D	E
23.	Protect rights of participants in research.	A	B	C	D	E
24.	Practice guided by principles of fidelity and respect for person.	A	B	C	D	E
25.	Maintain confidentiality of patient.	A	B	C	D	E
26.	Participate in activities of professional nursing associations.	A	B	C	D	E

Demographics: Circle the appropriate descriptor

27. A. Undergraduate Student B. Graduate Student C. Practicing nurse

28. A. Female B. Male

29. A. African American B. Asian/Pacific Islander C. White

D. Hispanic E. Native American

Please feel free to make comments:

 DW/MJS:bja 2/05

Appendix H

Questionnaire of NPVS-R (Thai version)

แบบวัดการให้คุณค่าเชิงวิชาชีพการพยาบาล (ฉบับปรับปรุง)

กรุณาระบุความสำคัญของการปฏิบัติงานพยาบาลในประเด็นดังต่อไปนี้ โปรดวงกลมตัวเลขที่กำหนดให้เพื่อแสดงระดับความสำคัญ

1 = ไม่สำคัญ และ 5 = สำคัญที่สุด

		ไม่สำคัญ	ค่อนข้างสำคัญ	สำคัญ	สำคัญมาก	สำคัญที่สุด
		1	2	3	4	5
1.	มีการประเมินตนเองขณะปฏิบัติงาน	1	2	3	4	5
2.	ขอคำแนะนำ/ความร่วมมือเมื่อไม่สามารถปฏิบัติความต้องการของผู้ป่วยได้	1	2	3	4	5
3.	คุ้มครองสุขภาพและความปลอดภัยของสาธารณชน	1	2	3	4	5
4.	มีส่วนร่วมในการตัดสินใจเกี่ยวกับนโยบายสาธารณะที่มีผลต่อการกระจายทรัพยากร	1	2	3	4	5
5.	มีส่วนร่วมในกระบวนการตรวจสอบผู้ร่วมงาน	1	2	3	4	5
6.	กำหนดมาตรฐานเพื่อเป็นแนวทางในการปฏิบัติงาน	1	2	3	4	5
7.	ส่งเสริมและรักษามาตรฐานเมื่อมีการจัดกิจกรรมการเรียนรู้ตามแผนของผู้เรียน	1	2	3	4	5
8.	ริเริ่มดำเนินการเพื่อปรับปรุงสภาพแวดล้อมในการปฏิบัติงาน	1	2	3	4	5
9.	แสวงหาการศึกษาเพิ่มเติมเพื่อปรับปรุงความรู้และทักษะ	1	2	3	4	5
10.	พัฒนาวิชาชีพด้วยการมีส่วนร่วมอย่างแข็งขันในกิจกรรมที่เกี่ยวข้องกับสุขภาพ	1	2	3	4	5
11.	ตระหนักถึงบทบาทของสมาคมพยาบาลวิชาชีพในการกำหนดนโยบายการดูแลสุขภาพ	1	2	3	4	5
12.	ส่งเสริมให้มีการเข้าถึงการพยาบาลและการดูแลสุขภาพอย่างเท่าเทียมกัน	1	2	3	4	5
13.	รับผิดชอบในการตอบสนองความต้องการด้านสุขภาพของประชากรที่มีความแตกต่างด้านวัฒนธรรม	1	2	3	4	5

		ไม่สำคัญ	ค่อนข้างสำคัญ	สำคัญ	สำคัญมาก	สำคัญที่สุด
		1	2	3	4	5
14.	มีความรับผิดชอบและสามัญสำนึกในการปฏิบัติหน้าที่ของตนเอง	1	2	3	4	5
15.	รักษาขีดความสามารถในการปฏิบัติงาน	1	2	3	4	5
16.	ปกป้องสิทธิของผู้ป่วยตามหลักศีลธรรมและกฎหมาย	1	2	3	4	5
17.	ปฏิเสธการมีส่วนร่วมในการพยาบาล หากขัดแย้งกับหลักจริยธรรมและคุณค่าในวิชาชีพของตนเอง	1	2	3	4	5
18.	ปฏิบัติหน้าที่เป็นผู้สนับสนุนผู้ป่วย	1	2	3	4	5
19.	มีส่วนร่วมในการวิจัยทางการพยาบาลและ/หรือใช้ผลงานวิจัยให้เหมาะสมกับการปฏิบัติงาน	1	2	3	4	5
20.	ให้การดูแลผู้ป่วยที่มีวิถีชีวิตแตกต่างกันโดยปราศจากอคติ	1	2	3	4	5
21.	ปกป้องสิทธิความเป็นส่วนตัวของผู้ป่วย	1	2	3	4	5
22.	เผชิญหน้ากับการปฏิบัติงาน/ผู้ปฏิบัติการที่น่าสงสัยหรือไม่เหมาะสม	1	2	3	4	5
23.	ปกป้องสิทธิของผู้เข้าร่วมงานวิจัย	1	2	3	4	5
24.	ปฏิบัติงานตามหลักความซื่อสัตย์และมีความเคารพต่อบุคคล	1	2	3	4	5
25.	รักษาความลับของผู้ป่วย	1	2	3	4	5
26.	มีส่วนร่วมในกิจกรรมของสมาคมพยาบาลวิชาชีพ	1	2	3	4	5

<u>ข้อมูลส่วนบุคคล: กรุณาวงกลมคำอธิบายที่เหมาะสมกับตัวท่าน</u>

27. 1. นักศึกษาระดับปริญญาตรี 2. นักศึกษาระดับบัณฑิตศึกษา 3. พยาบาลฝึกหัด

28. 1. เพศหญิง 2. เพศชาย

<u>ข้อเสนอแนะ:</u>

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Appendix I

The 81-item MCS-Thai for each factor after EFA (Thai and English)

The 81-item MCS-Thai for each factor after EFA (English and Thai)

Factor I: Respect Patient's Privacy and Keep Patient's Information Confidential (22 items)

เคารพความเป็นส่วนตัวและรักษาข้อมูลที่เป็นความลับของผู้ป่วย (22 ข้อ)

103. I will carefully keep a patient's confidentiality during nursing care conferences.
ฉันจะระมัดระวังการเปิดเผยความลับของผู้ป่วยขณะมีการประชุมปรึกษาทางการพยาบาล

101. I will keep a patient's secret if it will not harm others.
ฉันจะรักษาความลับของผู้ป่วยไว้เป็นอย่างดีหากข้อมูลนั้นไม่ก่อให้เกิดอันตรายแก่บุคคลอื่น

104. I will keep information confidential while recording a patient's details.
ฉันจะใช้ความรอบคอบในการบันทึกข้อมูลที่เป็นความลับของผู้ป่วย

100. I intend to keep a patient's secret without sharing with others.
ฉันตั้งใจที่จะเก็บรักษาความลับของผู้ป่วยที่ได้ฟังมาโดยไม่ไปบอกต่อคนอื่นๆ

99. I will not reveal patient's information to others without the patient's permission.
ฉันจะไม่ให้ผู้อื่นรู้ข้อมูลของผู้ป่วยก่อนที่จะได้รับอนุญาตจากผู้ป่วย

102. I will carefully keep patient's details confidential while reporting information to the next shift.
ฉันจะระมัดระวังการเปิดเผยความลับของผู้ป่วยขณะรับ-ส่งเวร

98. I will not expose a patient's illness information to the others, besides health care members.
ฉันจะไม่เปิดเผยข้อมูลเกี่ยวกับความเจ็บป่วยของผู้ป่วยต่อผู้ที่ไม่เกี่ยวข้อง

106. I absolutely will not share any of the patient's information without permission from the patient.
ฉันจะไม่นำเสนอข้อมูลของผู้ป่วยก่อนที่จะได้รับอนุญาตจากผู้ป่วยโดยเด็ดขาด

95. I will keep a patient's documents in a safe place.
ฉันจะเก็บหรือวางเอกสารส่วนตัวของผู้ป่วยไว้ในที่ที่บุคคลภายนอกไม่สามารถเข้าถึงได้

108. I will always ask a patient for permission before sharing his/her secret with others.
ฉันจะสอบถามผู้ป่วยถึงบุคคลที่ผู้ป่วยยินยอมให้รับรู้ข้อมูลที่เป็นความลับของผู้ป่วยได้

113. If I have to show a patient's pictures for educational learning, I will hide the patient's name and characteristics.
หากฉันต้องนำเสนอภาพของผู้ป่วยเพื่อนำมาใช้ในการศึกษา ฉันจะมีการปกปิดใบหน้าและชื่อของผู้ป่วย

107. I will always ask what information that patient wants to keep it confidential.
ฉันจะสอบถามผู้ป่วยว่าข้อมูลใดที่ต้องการให้ปกปิด

105. I will not use a private telephone while talking about the personal information of patient.
ฉันจะไม่พูดโทรศัพท์ขณะพูดคุยเกี่ยวกับข้อมูลที่เป็นความลับของผู้ป่วย

94. I will keep a patient's private information confidential.
ฉันจะเก็บรักษาข้อมูลส่วนตัวของผู้ป่วยไว้เป็นความลับ

93. I will not mention a patient's name or patient's information in public.
ฉันจะไม่เอ่ยชื่อผู้ป่วยหรือกล่าวพาดพิงถึงผู้ป่วยเมื่ออยู่ในที่สาธารณะ

96. I will log out from the system immediately after I have accessed a patient's information from a computer.
ฉันจะออกจากระบบทุกครั้งเมื่อเสร็จสิ้นการสืบค้นข้อมูลผู้ป่วยด้วยคอมพิวเตอร์

109. I will be careful not to expose the patient's body while providing care
ฉันจะระมัดระวังในการเปิดเผยร่างกายผู้ป่วยขณะให้การพยาบาล

110. I will expose only the part of the patient that I am providing care for.
ฉันจะเปิดเผยเฉพาะส่วนที่จำเป็นของร่างกายผู้ป่วยขณะให้การพยาบาล

97. I will give patient's information to the health care team for medical treatment and nursing care.
ฉันจะเปิดเผยข้อมูลของผู้ป่วยแก่ทีมสุขภาพเพื่อนำไปใช้ในการรักษาพยาบาลเท่านั้น

111. I will not post a patient's information online.
ฉันจะไม่นำข้อมูลของผู้ป่วยเสนอทางสื่อออนไลน์

112. I will not post a patient's photograph online.
ฉันจะไม่ถ่ายภาพของผู้ป่วยเผยแพร่ทางสื่อออนไลน์

92. I will not interfere with a patient's privacy unless it is related to their health.
ฉันจะไม่ก้าวก่ายเรื่องส่วนตัวที่ไม่มีผลต่อการดูแลสุขภาพของผู้ป่วย

Factor II: Respect for Patients (25 items)

ให้ความเคารพผู้ป่วย (25 ข้อ)

9. I will provide care according to a patient's values and beliefs.
ฉันจะให้การดูแลที่สอดคล้องกับคุณค่าและความเชื่อของผู้ป่วย

18. I will help patients to make autonomous decisions as they wishes.
ฉันจะช่วยให้ผู้ป่วยได้ตัดสินใจอย่างอิสระตามที่ผู้ป่วยต้องการ

19. I intend to help patients to take action after they make decisions.
ฉันมีความตั้งใจที่จะช่วยให้ผู้ป่วยได้กระทำตามที่ตัดสินใจโดยอิสระ

15. I commit to advocate for patients when they cannot protect their rights.
ฉันมุ่งมั่นที่จะพิทักษ์สิทธิให้กับผู้ป่วยเมื่อพบว่าผู้ป่วยกำลังถูกละเมิดสิทธิ

17. I commit to protect patients from being insulted.
ฉันมุ่งมั่นที่จะปกป้องผู้ป่วยจากการถูกผู้อื่นดูหมิ่นศักดิ์ศรี

24. I am very determined to protect vulnerable patients such as children, elderly, and psychiatric patients.
ฉันจะให้ความสำคัญอย่างมากกับการพิทักษ์สิทธิของผู้ป่วยกลุ่มเปราะบาง เช่น เด็ก ผู้สูงอายุ และผู้ป่วยที่มีปัญหาทางจิต

10. I will promote patient's actions according to religious beliefs if not violate others.
ฉันจะส่งเสริมการกระทำของผู้ป่วยตามความเชื่อทางศาสนา หากไม่ละเมิดผู้อื่น

20. I am ready to accept the different ideas of patients if they are conscious and authorized in making decisions.
ฉันพร้อมที่จะยอมรับความคิดเห็นที่แตกต่างของผู้ป่วยหากผู้ป่วยมีสติสัมปชัญญะและได้ตัดสินใจโดยอิสระ

12. I will promptly listen to patients' complaints and/or their questions.
ฉันจะให้เวลาเพื่อรับฟังปัญหา/คำถามจากผู้ป่วยด้วยความเต็มใจ

3. I will give information to the patients until reassure match their needs.
ฉันจะให้ข้อมูลกับผู้ป่วยจนมั่นใจว่าตรงกับความต้องการของผู้ป่วย

4. Whenever I give information to patients, I have to reassess that they can understand very well.
ภายหลังให้ข้อมูลแก่ผู้ป่วยทุกครั้ง ฉันจะต้องประเมินว่าผู้ป่วยเข้าใจข้อมูลนั้นๆได้ถูกต้อง

23. I do not pressure patients to do anything if they do not want to do.
ฉันจะไม่ให้ผู้ป่วยต้องฝืนใจทำในสิ่งที่ไม่ตรงกับความต้องการ

13. I am ready to accept if a patient refuses my suggestions.
ฉันพร้อมที่จะยอมรับหากผู้ป่วยจะปฏิเสธคำแนะนำจากฉัน

21. I will respect patients' ideas and decision even though I may disagree.
ฉันจะเคารพในความคิดและการตัดสินใจของผู้ป่วยไม่ว่าฉันจะเห็นด้วยหรือไม่ก็ตาม

8. I intend to help patients to make decisions that consistent with their values and beliefs.
ฉันตั้งใจที่จะช่วยให้ผู้ป่วยได้ตัดสินใจตามคุณค่า ความเชื่อของตนเอง

16. I will always respect a patient's rights even if the patient is in a coma stage.
ฉันจะไม่ละเมิดสิทธิของผู้ป่วยไม่ว่าผู้ป่วยจะอยู่ในสภาพที่รับรู้หรือไม่ก็ตาม

6. I try to seek health information from reliable resources to assist patients.
ฉันจะแสวงหาข้อมูลจากแหล่งที่เชื่อถือได้ทุกช่องทางเพื่อนำมาบอกเล่าให้ผู้ป่วยได้รับรู้ข้อมูลข่าวสารทางด้านสุขภาพ

14. I am pleased to provide a repeated information until the patient gets a clear answer without feeling bored/annoyed.
ฉันจะตอบคำถาม/ข้อสงสัยผู้ป่วยซ้ำๆเกี่ยวกับภาวะสุขภาพโดยไม่รู้สึกรำคาญ/เบื่อหน่าย

2. Before giving information, I have to ensure that the patient can perceive and understand it.
ก่อนให้ข้อมูล/คำแนะนำใดๆแก่ผู้ป่วย ฉันจะต้องประเมินจนแน่ใจว่าผู้ป่วยสามารถรับรู้และทำความเข้าใจในข้อมูล

22. Even though I disagree about patient's decisions, I will let him/her make decisions.
แม้ฉันจะไม่เห็นด้วยกับการตัดสินใจของผู้ป่วยแต่ฉันก็จะไม่ขัดขวางการตัดสินใจของเขา

26. I try to enhance family members to collaborate with health care team.
ฉันจะส่งเสริมให้ครอบครัวมีส่วนร่วมในการตัดสินใจเกี่ยวกับสุขภาพของผู้ป่วย

27. I will cooperate with family members to search for proxy person who can make decision for patient.
เมื่อผู้ป่วยตัดสินใจเองไม่ได้ ฉันจะประสานกับครอบครัวเพื่อค้นหาผู้ที่มีสิทธิและสามารถตัดสินใจแทนผู้ป่วยได้

5. I am pleased to provide a repeated information until it is clearly understood by the patient.
ฉันเต็มใจที่จะให้ข้อมูลผู้ป่วยซ้ำๆเพื่อให้มั่นใจว่าผู้ป่วยเข้าใจข้อมูลอย่างชัดเจน

11. I will not try to use my ideas or beliefs to judge patients' thoughts or behaviors.
ฉันจะพยายามหลีกเลี่ยงการใช้ความคิด ความเชื่อของตนเอง ไปตัดสินความคิด/การกระทำของผู้ป่วย

7. I will give information every time when I provide care except in emergency cases for saving their life.
ฉันจะอธิบายถึงสิ่งที่ฉันจะปฏิบัติต่อผู้ป่วยทุกครั้ง ยกเว้นกรณีฉุกเฉินเร่งด่วนเพื่อช่วยชีวิตผู้ป่วยเท่านั้น

Factor III: Providing Care Equally to Each Patient (9 items)

ดูแลผู้ป่วยแต่ละรายอย่างเท่าเทียมกัน (9 ข้อ)

72. I will provide care to all patients with the same nursing standards.
ฉันจะให้การดูแลผู้ป่วยทุกคนด้วยมาตรฐานการพยาบาลเดียวกัน

71. I will honor all patients equally.
ฉันจะให้เกียรติผู้ป่วยทุกคนอย่างเท่าเทียมกัน

73. I will help all patients under my care receive equal rights.
ฉันจะช่วยให้ผู้ป่วยทุกคนภายใต้การดูแลของฉันได้รับสิทธิอย่างเท่าเทียมกัน

74. I will try my best to help all patients to be treated equally.
ฉันจะพยายามอย่างเต็มที่ที่จะช่วยให้ผู้ป่วยทุกคนได้รับการดูแลอย่างเสมอภาค

66. I will treat all patients equally, regardless of educational level or social status.
ฉันจะให้การดูแลผู้ป่วยทุกรายอย่างเท่าเทียมกันโดยไม่คำนึงถึงระดับการศึกษาหรือสถานะทางสังคม

64. I will use polite and friendly words with patients.
ฉันจะใช้คำพูดที่สุภาพและเป็นมิตรต่อผู้ป่วย

67. I will provide care to patients of different races or religions without bias.
ฉันจะให้การดูแลผู้ป่วยที่มีเชื้อชาติหรือนับถือศาสนาต่างจากฉันโดยปราศจากอคติใดๆ

65. I will provide gentle care to every patient.
ฉันจะให้การดูแลผู้ป่วยด้วยความนุ่มนวล อ่อนโยน

69. I will not discriminate in the care of a patient, even if they have a different opinion or belief.
ฉันจะไม่เลือกปฏิบัติในการดูแลผู้ป่วยแม้ว่าเขาจะมีความคิดเห็นหรือมีความเชื่อที่แตกต่างจากฉัน

Factor IV: Causing No Harm to Patients (12 items)

ไม่ทำให้ผู้ป่วยเกิดอันตราย (12 ข้อ)

31. I will not get angry or irritated towards patients.
ฉันจะไม่แสดงอารมณ์โกรธหรือหงุดหงิดใส่ผู้ป่วย

33. I will not make patients feel more anxious while being admitted to hospital.
ฉันจะไม่ทำให้ผู้ป่วยรู้สึกกังวลใจเพิ่มขึ้นขณะรับการรักษาในโรงพยาบาล

29. I will never let patients suffer from my actions towards them.
ฉันจะไม่มีวันทำให้ผู้ป่วยทุกข์ใจจากกิริยาท่าทางของฉันที่แสดงต่อเขา

32. Even if a patient uses aggressive words and gestures towards me, I will keep calm.
แม้ผู้ป่วยจะใช้คำพูดและท่าทางก้าวร้าวใส่ฉัน ฉันก็จะไม่ใช้อารมณ์ตอบโต้ผู้ป่วย

34. I am determined not to increase patients' pain from my nursing practice.
ฉันตั้งใจอย่างแน่วแน่ที่จะไม่เพิ่มความเจ็บปวดของผู้ป่วยจากการปฏิบัติการพยาบาลของฉัน

42. I will not use techniques or solutions that will cause patients' more pain from wound dressing.
ฉันจะไม่ใช้วิธีการหรือน้ำยาที่ทำให้ผู้ป่วยเจ็บปวดมากขึ้นจากการทำแผล

41. I will not use suction techniques that cause suffering and pain of patients.
ฉันจะไม่ใช้วิธีการดูดเสมหะที่ทำให้ผู้ป่วยเจ็บปวดทุกข์ทรมาน

30. I will not use words or actions that make the patient feel embarrassed or inferior absolutely.
ฉันจะไม่ใช้คำพูดหรือกิริยาท่าทางที่ทำให้ผู้ป่วยรู้สึกอับอายหรือด้อยศักดิ์ศรีเป็นอันขาด

40. In case of intravascular injections, I will try to find the best way to reduce irritation.
ในการให้ยาที่ระคายเคืองหลอดเลือด ฉันจะพยายามหาวิธีที่ดีสุดเพื่อไม่ให้ผู้ป่วยเจ็บปวด

35. In case of sensitive groups such as AIDS patients, cancer patients, patient at the end of life etc., I will be careful in using words that may affect their feelings and emotions.
ในกลุ่มเปราะบาง เช่น ผู้ป่วยเอดส์ ผู้ป่วยมะเร็ง ผู้ป่วยระยะสุดท้าย ฯลฯ ฉันจะไม่ใช้คำพูดที่ทำให้เขาสะเทือนใจหรือน้อยใจ

28. I will not cause patient suffering because of my words.
ฉันจะไม่ทำให้ผู้ป่วยทุกข์ใจเพราะคำพูดของฉัน

36. I will be careful while working in order to prevent patients from harmed or disabled.
ฉันจะปฏิบัติงานด้วยความไม่ประมาทเพื่อไม่ให้ผู้ป่วยเกิดอันตรายหรือพิการ

Factor V: Doing Good for Patients (8 items)

ปฏิบัติในสิ่งที่เป็นผลดีต่อผู้ป่วย (8 ข้อ)

48. I intend to dedicate myself and time to help patients receive high quality care.
ฉันตั้งใจที่จะอุทิศตนและเวลาเพื่อช่วยให้ผู้ป่วยได้รับการดูแลที่มีคุณภาพสูง

50. I will take care of the patient throughout the duration of time, no matter how busy the work is.
ฉันจะดูแลเอาใจใส่ใจผู้ป่วยตลอดระยะเวลาของการปฏิบัติงานไม่ว่างานจะยุ่งเพียงใด

49. I am pleased and willing to take care of patients.
ฉันรู้สึกยินดีและเต็มใจที่ได้ดูแลช่วยเหลือผู้ป่วย

47. I am committed to serving patients despite sacrificing personal happiness.
ฉันมุ่งมั่นที่จะทำประโยชน์ให้กับผู้ป่วยแม้จะต้องเสียสละความสุขส่วนตัว

52. I am ready to assist patients without asking for.
ฉันพร้อมที่จะให้การช่วยเหลือผู้ป่วยโดยไม่ต้องให้ร้องขอ

56. I will take care of patients until I am sure that the patient is safe after the medication is given.
ฉันจะดูแลผู้ป่วยจนมั่นใจว่าผู้ป่วยปลอดภัยภายหลังจากที่ฉันให้ยา

53. I will reveal understanding and concern to the patient.

ฉันจะแสดงให้ผู้ป่วยรับรู้ถึงความเข้าใจและความห่วงใยที่ฉันมีต่อเขา

51. I will always cheer up the patients.

ฉันจะคอยเป็นกำลังใจให้กับผู้ป่วย

Factor VI: Telling the Truth to Patient and Healthcare Team (5 items)

ให้ข้อมูลที่เป็นจริงต่อผู้ป่วยและทีมสุขภาพ (5 ข้อ)

84. I will provide clear and truthful information about patients' health until they understand very well.

ฉันจะต้องบอกความจริงเกี่ยวกับสุขภาพอย่างชัดเจนครบถ้วนจนมั่นใจว่าผู้ป่วยเข้าใจอย่างดี

83. I have to assess the patient's ability to accept the truth such a bad news.

ฉันจะต้องประเมินความสามารถของผู้ป่วยในการยอมรับความจริงที่เป็นข่าวร้าย

88. I will report the mistakes of others.

ฉันจะรายงานความผิดพลาดของผู้อื่นตามความเป็นจริง

85. In cases where the patient needs information beyond my duties. I will coordinate with those involved in providing information to patients.

กรณีที่ผู้ป่วยต้องการข้อมูลที่เกินขอบเขตหน้าที่ของฉัน ฉันจะประสานกับผู้ที่เกี่ยวข้องในการให้ข้อมูลแก่ผู้ป่วย

82. I will write a nursing report on what I have done.

ฉันจะเขียนบันทึกทางการพยาบาลในสิ่งที่ฉันได้สังเกตเห็น/กระทำจริงเท่านั้น

VITAE

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2. PhD Thesis Grant from Graduate School, Prince of Songkla University, Thailand.

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List of Publication and Proceedings

Perngyai, C., Chaowalit, A., & Nasae, T. (2017). Moral Commitment to Patient Care among Thai Baccalaureate Nursing Students. The international conference on ethics, esthetics and empirics in nursing: Driving forces for better health. The Faulty of Nursing, Prince of Songkla University, July 5-7, 2017, the 60th

anniversary of His Majesty the King's Accession to the throne international convention center, Thailand, Oral Presentation.

Perngyai, C., Chaowalit, A., & Nasae, T. (2017). Moral Commitment of Nursing Students. TNMC & WANS International Nursing Research Conference 2017: Culture, Co-creation, and Collaboration for Global Health, Thailand Nursing and Midwifery Council, October 20-22, 2017, Miracle Grand Convention Hotel, Thailand, Oral Presentation.