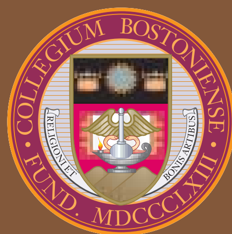
Ethics Tool Database

BOSTON COLLEGE

WILLIAM F. CONNELL SCHOOL OF NURSING



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COMPETENCE 1.0

Assesment oF Patient Competence (APC)

RELIABILITY: Not provided

VALIDITY: The instrument was reviewed for face validity by both clinicians and lawyers.

BACKGROUND: Unknown

PURPOSE: Determines physicians' knowledge of applying legal standard for determining competence; and, determines physicians' abilities to assess competence by physician age or specialty.

WHERE TO FIND THE ARTICLE: Markson, L., Kern, D., Annas, G. and Glantz, L. (1994). Physician assessment of patient competence. Journal of American Geriatrics Society, 42, 1074-1080.

DESCRIPTION: The tool has specific questions about a patient scenario and questions about the law. Part I - scenario based on Massachusetts Appelate Court decision: Lane v. Cardura, 6 Mass. App. Ct. 377.1978. Part II - series of multiple choice, theoretical questions about the law pertaining to competence. The entire tool is included in the above-mentioned article.

FACTORS 2.0

Ethics Stress Scale-Luna-Tymchuk

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: This new instrument for measuring the stress that health care professionals may experience as they face ethical issues with their patients, colleagues or research subjects was developed by the author to use along with Dr. Anna Omery's Moral Reasoning Questionnaire and Lazarus and Folkman's Way of Coping in her dissertation research on "Psychological Factors Influencing Ethical Decision Making". The instrument was tested in 1990.

PURPOSE: Measures stress related to ethical decision-making by health care professionals.

WHERE TO FIND THE ARTICLE: Not available.

DESCRITPTION: The scale consists of 43 items; participants rank each for frequency of encounter and choose a number reflecting intensity of related stress, 0 = never, 1 = mild to 7 = very strong.

Decision Making

FACTORS 2.0

Attribution of Responsibility Instrument (ARI)

RELIABILITY: A pilot study of 53 senior female BSN students and 25 female graduate nursing students yielded CronbachÕs alpha reliability coefficient of .85. Stability was established by readministering the questionnaires to 25 subjects were randomly selected from the original sample of 78 subjects. Five weeks after the initial administration; test-retest reliability coefficient was .63. The amount of attribution of responsibility assigned did not differ for the two groups (t = 0.02, p>. 05). The dilemma solution did not differ significantly between the groups.

VALIDITY: Content validity was established by two social psychologists who agreed that each statement represented the designated ARI level.

PURPOSE: Measures the attribution of responsibility in relation to ethical/moral dilemmas.

BACKGROUND: Developed to evaluate the influence of formal education on three selected factors: ethical/moral reasoning, attribution of responsibility, and ethical/moral dilemma resolution. The results suggest that undergraduate and graduate nursing programs must place more emphasis on identifying dilemmas, increasing ethical/moral reasoning levels and attributing responsibility in a justifiable manner.

WHERE TO FIND THE ARTICLE: Felton, G. M. and Parsons, M.A. (1987). The impact of nursing education on ethical/moral decision-making. Journal of Nursing Education, 26, 7-11.

DESCRITPTION: The Attribution of Responsibility Instrument was developed to measure the attribution of responsibility in relation to ethical/moral dilemmas. ARI measured the commission, foreseeability, intentionally, and justification levels of responsibility.

Decision Making

FACTORS 2.0

Autonomy Preference Index (API)

RELIABILITY: Test-retest: 0.84 for decision making and 0.83 for information seeking CronbachÕs alpha: 0.82 for each.

VALIDITY: Concurrent validity of the decision making scale was established by correlation with an empirically related global item appended to the instrument; r = 0.54, p = < 0.0001. Convergent validity was obtained by administering the decision making scale to diabetic patients.

BACKGROUND: In an era in which patient autonomy has become a tenet of medical ethics, relatively little attention has been given to the question of how much involvement in their own care patients really want. A modified Delphi study involving 13 clinicians, medical sociologists, and ethicists was organized to assist in identification of the key measurable dimensions of patients' preferences for autonomy.

PURPOSE: Measures patients' preferences for two identified dimensions of autonomy.

WHERE TO FIND THE ARTICLE: Ende, J., Kazis, L., Ash, A. and Moskowitz, M. (1989) Measuring patients' desire for autonomy; decision making and information-seeking preferences among medical students. Journal of General Internal Medicine, 4, 23-30.

DESCRITPTION: The API consists of two scales: an 8 item scale on information seeking and a 15 item scale on decision making. Items scored on a 5 point Likert scale and total scores were adjusted linearly to range from 0 (no desire) to 100 (strong desire). Three clinical vignettes were used to represent different levels of illness severity for the decision making scale.

Decision Making

FACTORS 2.0

The Inventory of Congnitive Biases in Medicine (ICBM)

RELIABILITY: Kuder-Richardson 20 internal consistency reliability: 0.62 for faculty and 0.42 for students. The short length (22 items) of the ICBM prevented the test from having a higher reliability. Group homogeneity was greater in student and resident group than the faculty group.

VALIDITY: The ICBM appears to have content validity. Items were developed from actual clinical experiences reported by physicians and were scrutinized for inclusion from the perspectives of clinical medicine, cognitive psychology and statistics. Construct validity is supported by the fact that the faculty scored higher (7.5%) than did students and residents.

BACKGROUND: The ICBM was developed to evaluate the effectiveness of educational interventions aimed at minimizing the biases associated with predictable information-processing tendencies when making medical decisions. It can serve as a training tool in the educational process, and be used to compare groups of physicians or physicians-in-training on the dimension of cognitive bias.

PURPOSE: Measures the influence of cognitive biases on medical decisions.

WHERE TO FIND THE ARTICLE: Hershberger, P., Part, H., Markert, R., Cohen, S. and Finger, W. (1994). Development of a test of cognitive bias in medical decision-making. Academic Medicine, 69 (10), 839-842.

DESCRITPTION: The ICBM contains 22 medical scenarios in which respondents choose between alternatives that represent bias-prone or statistically based decisions.

Decision Making

ROLES 3.0

Mazur's Patient Preference Tool (MPPT)

RELIABILITY: Not provided.

VALIDITY: Not provided

BACKGROUND: Unknown.

PURPOSE: To access the level of involvement patients want in decision making related to the acceptance or rejection of an invasive medical intervention and whether their preference for decision making is related to their preference for qualitative (verbal) or quantitative (numeric) information about the risks of the procedure.

WHERE TO FIND THE ARTICLE: Mazur, D. and Hickam, D. (1997). Patients' preferences for risk disclosure and role in decision making for invasive medical procedures. Journal of General Internal Medicine, 12, 114-117.

DESCRITPTION: Definitions were given for procedure and risk. In a structured interview, patients were asked to answer 4 questions related to their preferences in information disclosure about procedures. A four item demographic tool asked: age, educational level, present health and medical conditions.

Decision Making

ROLES 3.0

Krantz Health Opinion Survey (HOS)

RELIABILITY: Reliabilities of The Behavioral Involvement and Information subscales were .74 and .76, respectively. Kuder-Richardson 20 reliability of the HOS for two subsequent college samples remained over .74 for subscales and total scale. Test-retest reliabilityÕs for the HOS components were .74, .71, and .59 for the total score, Behavioral Involvement scale, and Information scales, respectively. There is a slight but non-significant tendency for females to score somewhat higher than males on all HOS scales.

VALIDITY: Predictive Validity: The HOS successfully discriminated between a criterion group of high self-care subjects and the general student population. Discriminate vadility: Both subscales show discriminate validity. Construct validity: is still being tested.

BACKGROUND: Although current ideology suggests patients would be active partners in decision making about their care, the literature suggests that patients wish to be informed but not involved.

PURPOSE: Measure patients' attitudes toward treatments.

WHERE TO FIND THE ARTICLE: Krantz, D.S., Baum, A., Wildeman, M.V. (1980). Assessment of preferences for self-treatment and information in health care. Journal of Personality and Social Psychology, 39(5): 977-990.

DESCRITPTION: HOS was developed to measure patient attitudes toward treatment approaches and uses two subscales: Information (7 items) and Behavior (9 items). A high score denotes favorable attitudes toward self-directed or informed treatment participation, while a low score denotes a passive attitude. The total combined score of the 2 a priori subscales provides an overall measure of attitude toward medical treatment.

Decision Making

SATISFACTION 4.0

Satisfaction with Decision Scale (SWD)

RELIABILITY: Cronbach's alpha is 0.86.

VALIDITY: Discriminate validity, tested by performing principal-components analysis of items pooled from the SWD scale and two conceptually related measures, was good.

BACKGROUND: Patient satisfaction measures have previously addresses satisfaction with medical care, satisfaction with providers, and satisfaction with outcomes, but not satisfaction with the health care decision itself. The SWD was developed in the context of post-menopausal hormone-replacement therapy decisions to help understand specific dynamics of the decision itself.

PURPOSE: The SWD measures patient satisfaction with health care decisions.

WHERE TO FIND THE ARTICLE: Holmes-Rovner, M., Kroll, J., Schmitt, N., Rovner, D., Breer, L., Rothert, M., Padonu, G. and Talarczyk, G. (1996). Patient satisfaction with health care decisions: The Satisfaction with Decision Scale. Medical Decision-Making, 16 (1), 58-64.

DESCRITPTION: The SWD is a six-item scale and each item is scored on a 5 point scale ("very certain would not take " to "very certain would take"). It can be used in health care settings to evaluate decision-assisting technologies or patient-provider interactions aimed at involving patients in decision making.

Decision Making

SATISFACTION 4.0

Job Satisfaction Scale

RELIABILITY: Internal consistency: alpha = 0.86.

VALIDITY: Not provided.

BACKGROUND: Tool designed by Price and Mueller, 1981.

PURPOSE: Measures job satisfaction.

WHERE TO FIND THE ARTICLE: Packard, J. & Motowidlo, S. (1987) Subjective stress, job satisfaction and job performance of hospital nurses. Research in Nursing & Health, 10, 253-261.

DESCRITPTION: 7-subscale instrument incorporating 52 items scored in a variety of ranges. Some questions are indicated on a 5 point Likert scale ranging from = strongly disagree to 5 = strongly agree.

STYLES 5.0

Case Vignettes of Restrictive Situations in Psychiatric Care (RSPC)

RELIABILITY: Test-retest reliability with 20 nurse specialists demonstrated no significant differences in rankings for all interventions for each vignette.

VALIDITY: Content validity was assured by selecting situations representative of a potential conflict between client needs, rights, and available resources. The vignettes and ethics-based interventions were reviewed by a psychiatric nurse ethicist who confirmed that the intervention accurately represented the appropriate ethical principle. Content experts reviewed the vignettes and the interrater agreement was .88.

BACKGROUND: Not known.

PURPOSE: Measures nurses' ethically-basednursing interventions in selected situations illustrate the discipline's ethical relationship to clients and society.

WHERE TO FIND THE ARTICLE: Garritson, S.H. (1988). Ethical decision making patterns. Journal of Psychosocial Nursing, 26(4), 22-29.

DESCRITPTION: The tool contains three case vignettes depicting restrictive situations in psychiatric care. Respondents ranked three interventions according to their agreement with the approach and rationale represented by the intervention. In addition, the respondent was asked to comment onthe intervention chosen first.

Decision Making

STYLES 5.0

Participatory Decision-Making Styles (PDMS)

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: A representative cross-sectional sample of patients participating in the Medical Outcomes Study characterized each physician's style by using a self-reported questionnaire. A single averaged style score was generated for each physician. Style scores were compared among physicians who differed in age, sex, minority status, specialty, primary care training or training in interviewing skills, satisfaction with professional autonomy, and practice volume.

PURPOSE: Measures how patients rate their physician's participatory decision-making style.

WHERE TO FIND THE ARTICLE: Kaplan, S., Greenfield, S., Gandek, B., Rogers, W. and Ware, J. (1996). Characteristics of physicians with participatory decision-making styles. Annals of Internal Medicine, 124, 497-504.

DESCRITPTION: The PDMS is a three-item scale. Patients are asked to rate their physician's style on a five-point scale in respond to the following three questions: (1) If there were a choice between treatments, would this doctor ask you to help make the decision?; (2) How often does this doctor make an effort to give you some control over your treatment?; (3) How often does this doctor ask you to take some of the responsibility for your treatment? Scoring instructions are provided.

Ethical Behaviors

ANA CODE (EB/Code) 1.0

Judgements About Nursing Decisions (JAND)

RELIABILITY: Cronbach's coefficient alpha for column B ranged .66 - .73. Reliability for column A scores is low; it is not recommended for use as a separate scale in hypothesis testing.*

VALIDITY: Demonstrated by significant correlation with the DIT and comparison of results for samples of professional and technical nurses.

BACKGROUND: Case Vignettes were derived from approximately 100 stories from practicing nurses and were assessed by nurse clinicians as representative of practice occurrences; these were further developed with consultants and the Code for Nurses.

PURPOSE: To measure moral behavior in nursing practice in two dimensions: (1) professionally ideal moral behavior congruent with the Code for Nurses and (2) perception of realistically likely moral behavior in nursing practice.

WHERE TO FIND THE ARTICLE: Ketefian, S. (1982). Tool development in nursing construction of as scale to measure moral behavior. Journal of New York State Nurses Association, 13, 13-19.

DESCRITPTION: The tool consists of six vignettes with yes/no responses regarding what ideally should be done and what realistically is likely to be done by the nurse facing the ethical dilemma posed in the vignette. The vignettes were tested in a study of 43 professional nurses and 36 nurse technicians.

ADAPATION/COMMENTS: *In her book, Moral Reasoning and Ethical Practice in Nursing: An Integrative Review, which was co-authored with I Ormond, (1988, NLN Pub. No. 15-2250) Ketefian describes a third, "C" column which asks explicitly what participants would do. The C column was found to have low reliability and is not used *See C.A. Rooks (1994) adaptation of Ketefian tool -EB Code -002

Ethical Behaviors

ANA CODE (EB/Code) 1.0

Judgements about Nursing Decisions (JAND), Adaptations by Rooks (1994)

RELIABILITY: Internal consistency reliability for Column B responses was tested using Cronbach's coefficient alpha which showed a range from .66 to .73 across different samples of RNs (Ketefiam, 1987). For this study, the Column A responses showed a coefficient alpha of .70; and for Column B responses, .71.

VALIDITY: Content Validity was established by Ketefian in 1982 and 1987, Convergent Validity was established by testing with the JAND and the DIT. The Pearson product moment correlation of Column B response with the DIT was .19, $p < .05$; shared variances was only 3.6%. Construct validity was established by use of the known group's technique in 1990.

PURPOSE: The purpose of the study was to identify the moral choices and actions of foreign-educated & domestic nurses in hypothetical ethical dilemmas.

BACKGROUND: The JAND was adapted for the purpose of this study and involved 33 European American, 26 African American, and 17 Filipino nurse subjects. Moral choice was defined as the response to Column A of the JAND; moral action was defined as the response to Column B of the JAND.

WHERE TO FIND THE ARTICLE: Rooks, C.A. (1994). Cultural aspects of moral actions & moral choices in nursing. (Dissertation: University of Maryland, Baltimore, graduate school).

DESCRITPTION: The JAND was adapted by adding one additional item to the set of statements following each of the six vignettes. This item allowed nurse subjects to write in other possibilities for action which was not listed among the choices but which the nurse should and/or would perform.

CARING (EB/Caring) 2.0

Caring Behaviors Assessment Tool CBA

RELIABILITY: Interrater: less an 0.75 were recategorized into more appropriated subscales Internal consistency. Cronbach's alpha for each of the seven subscales. Reliability coefficients: ranged for 0.66 to 0.90.

VALIDITY: Face and content validity were established by a panel of four content specialists familiar with Watson's conceptual model.

BACKGROUND: The tool operationnalizes the "carative" factors that nurses use as a framework for the caring process, as proposed by Jean Watson.

PURPOSE: To identify nursing behaviors perceived as indicators of caring by patients.

WHERE TO FIND THE ARTICLE: Cronin, S. & Harrison, B. (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. Heart & Lung, 17(4), 374-380.

DESCRITPTION: The CBA lists 61 nursing behaviors ordered in 7 subscales that are congruent with JeanWatson's carative factors. Watson's 6th caratives factor was omitted as a subscale as the authors assumed that creative problem-solving caring process was inherent in nursing. Authors did not give ranges for responses. A 5 Point Likert type scale was used. Interviews of 22(17 men and 5 women) who had been hospitalized in the CCU were conducted. Following the interview, subjects were asked to complete the CBA.

Ethical Behaviors

CARING (EB/Caring) 2.0

Recall Tasks & Clinical Dilemma Questionnaire

RELIABILITY: Interrater reliability between 75 to 84% agreement was established with Lyons Coding Scheme.

VALIDITY: Not reported

BACKGROUND: Gilligan's theory of moral development and Kolhberg's theory of moral development structured this study of 199 nursing and medical students who described a real-life moral dilemma and responded to a hypothetical clinical moral dilemma. The study included 68 female 3rd year nursing students, 25 female 3rd & 4th year medical students, & 25 male 3rd & 4th year medical students.

PURPOSE: This study was conducted to answer the following questions: 1) To what extent are care considerations reflected in the moral reasoning of female nursing students?; 2) Are care considerations reflected more in the moral reasoning of nursing students (all female) than in medical students overall?; 3) Are care considerations reflected more often in the moral reasoning of female nursing students than in female medical students?; 4) Are care considerations reflected more often in the moral reasoning of female medical students than in male medical students?; and, 5) Are personal dilemmas associated with a higher use of care considerations than impersonal dilemmas?

WHERE TO FIND THE ARTICLE: Peter, E. & Gallop, R. (1994). The ethic of care: A comparison of nursing and medical students, IMAGE, 26(1), 47-51.

DESCRITPTION: A modified version of an instrument developed by Pratt following Lyons 1982 face-to-face interview. The questionnaire consists of two parts: Part I: the Recall Tasks and Part II: the Clinical Dilemma. In Part I, personal dilemmas were described. In Part II, a dilemma is posed. Lyons Coding Scheme was chosen to determine the number of care and justice considerations made in response to the Recall Task and Clinical Dilemma.

Ethical Behaviors

CARING (EB/Caring) 2.0

Caring Assessment Report Evaluation Q-Sort (CARE-Q)

RELIABILITY: Reported in: Larson, P. (1981). Oncology patients' and professional nurses' perceptions of important caring behaviors. Doctoral Dissertation: University of California, San Francisco. University Microfilms #81-16511.

VALIDITY: Reported in: Larson, P. (1981). Oncology patients' and professional nurses' perceptions of important caring behaviors. Doctoral Dissertation: University of California, San Francisco. University Microfilms #81-16511.

BACKGROUND: Not Known.

PURPOSE: To obtain perceptions of important nurse caring behaviors.

WHERE TO FIND THE ARTICLE: McDermott Keane, S., Chastain, and B. and Rudisill, K (1987). Caring nurse-patient perceptions, Rehabilitation Nursing, 12(4), 182-188.

DESCRITPTION: The CARE-Q consists of 50 behavioral items ordered in six sub scales of caring. Using the Caring Assessment Report Evaluation Q-SORT (CARE-Q), 26 patients and 26 nurses were asked to assign a degree of importance to each of the 50 nursing caring behaviors in the CARE-Q.

CARING (EB/Caring) 2.0

Nurse Caring Questionnaire (NCQ)

RELIABILITY: Alpha internal consistency reliability estimates of .99 each.

VALIDITY: The convergent validity is confirmed by the aggregate measures of caring.

BACKGROUND: For this study involving 91 hysterectomy patients & their nurses, the measurement of congruence occurred within the context of a larger study. The larger study used a naturalistic approach to define caring and its relationship to productivity and health outcome variables. Within the larger study the conceptual domain of caring was specified through the use of multiple measures and methods. Based on qualitative data from the domain specification phase, the NCQ & PCQ were developed.

PURPOSE: To measure the presence of caring which had occurred between specific nurse-patient interactions.

WHERE TO FIND THE ARTICLE: Valentine, K. (1991). Nurse-patient caring: Challenging our conventional wisdom. In D. Gaut and M. Leininger (Eds.). Caring: The Compassionate Healer, 99-113. NLN Pub: 15-2401.

DESCRITPTION: The NCQ & PCQ each consists of 61 items scored on a 5 point Likert scale ranging from 1 = strongly disagree to 3 = neither agree/nor disagree to 5 = strongly agree.

Ethical Behaviors

CARING (EB/Caring) 2.0

Caring Behaviors Inventory (CBI)

RELIABILITY: Test-retest reliability was established: r = .96, p =.000, rho = .88, p = .000. The alpha coefficient was .83. Internal consistency reliability was: Alpha coefficient of .96 for the combined nurses and patient sample. Unpaired t-test revealed that the groups were different: t = 3.01, of = 539, p = .003.

VALIDITY: Construct validity of the contrasted groups nursing staff (n= 278) and patient (n= 263) was established.

BACKGROUND: Nursing caring and human caring have been studied from philosophical and ethical perspectives. The transpersonal care theory was developed by Watson (1988) based on this idea. Leininger (1980) described caring as human acts and processes that are concerned with helping others meet the needs of those requiring care.

PURPOSE: To measure caring behaviors.

WHERE TO FIND THE ARTICLE: Wolf, Z., Giardono. E., Osborne, P. and Ambrose, M. (1994). Dimensions of nurse caring. IMAGE: Journal of Nursing Scholarship, 26 (2), 107-111.

DESCRITPTION: The Caring Behaviors Inventory is a 43-item instrument. A four point Likert scale is used to elicit responses from (1) strongly disagree to (4) strongly agree on each item.

CARING (EB/Caring) 2.0

Care and Justice Interview

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The manual is designed for researchers interested in analyzing moral dilemma data to determine how a person uses considerations of rights (justice) or response (care). The coding method distinguishes considerations of justice and considerations of care in construction, resolution and evaluation of moral conflict and choice.

PURPOSE: Lyon's Coding Scheme tests Gilligans' hypotheses that justice and care are distinct modes of moral judgment & gender related. The coding scheme also makes it possible to examine the relationship between modes of moral judgment & modes of self-definition.

WHERE TO FIND THE ARTICLE: Lyons, N. (1982). Conceptions of self and morality and modes of moral choice: identifying justice and care in judgments of actual moral dilemmas. Unpublished doctoral dissertation. Harvard University, Cambridge.

DESCRITPTION: The coding steps are: identifying the dilemma components, identifying the considerations, and categorizing considerations. The coding scheme was then used in a study of moral dilemmas reported by a sample of 36 individuals (18 males & 18 females).

COPING (EB/Caring) 2.0

Jalowiec Coping Scale

RELIABILITY: No information provided.

VALIDITY: No information provided.

BACKGROUND: This questionnaire concerns how one copes with stress and tension, and how one handles stressful situations.

PURPOSE: To assess frequency and helpfulness of specified coping strategies.

WHERE TO FIND THE ARTICLE: Jalowiec, A. (1989). Revision & Testing of the Jalowiec Coping Scale. Loyola University of Chicago.

DESCRITPTION: Sixty item objective questionnaires list sixty specific coping behaviors. Researcher specifies stressor under investigation by filling in the blank in introductory paragraph. Participants indicates responses to each item on two Likert scales, first identifying how often they have used the strategy, and second, indicating how helpful it has been to them.

Ethical Behaviors

COPING (EB/CP) 3.0

Coping Styles Inventory (CSI)

RELIABILITY: The alpha coefficients for the primary factors of the CSI ranged form .71 to .94. Tested-retested reliability coefficients ranged for .67 to .83.

VALIDITY: No information provided.

BACKGROUND: The format of the CSI adapts 49 items from the Ways of Coping checklist (Falkman & Lazaras, 1980) sixty items were generated by the authors.

PURPOSE: The CSI assesses the extent to which a person uses certain coping thoughts and behaviors in response to a particular stress.

WHERE TO FIND THE ARTICLE: Tobin, D., Holroyd, K., Reymolds, R. & Wigal, J. (1989). The hierarchical factor structure of the Coping Strategies Inventory. Cognitive Therapy & Research, 13(4): 343-361.

DESCRITPTION: Seventy two statements depicting various ways of dealing with terminal illnesses are rated by the respondents on a 5 item Likert format ranging from "not at all" to "very much". The CSI has eight components: problem solving, cognitive restructuring, express emotions, social support, problem avoidance, wishful thinking, and self-criticism and social withdrawal. The tool was used in a study of 44 spouses of patients admitted to Hospice. (Willert, M., Beckwith, B., Holm,J. and Beckwith , S. (1995). A preliminary study of the impact of terminal illness of spouses: social support and coping strategies. The Hospice Journal, 10(4), 35-48.).

EMPATHY (EB/EM) 4.0

Behavior Test of Interpersonal Skills (BTIS)

RELIABILITY: Non-reactivity of the empathy categories is demonstr ated when no significant differences result between subjects' initial scores and scores 6 and 16 weeks later.

VALIDITY: Content validity was established with input from health professional & through comparison of the content of actual nurse - patient interactions with BTIS situations. Moderate support for construct validity was demonstrated when the "content" category correlated positively (r= .32 - .51) with five tests. Evidence for criterion-related validity resulted when positive correlations (p< .05) were found between empathy components of the BTIS, and peer & supervisor ratings of nurses.

BACKGROUND: Not Known.

PURPOSE: The BTIS measures nurse-expressed empathy and consists of situations involving patients who have been role-played and recorded on videotape.

WHERE TO FIND THE ARTICLE: Olson, J. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy and patient distress. IMAGE, 27(4), 317-322.

DESCRITPTION: The BTIS provides a standardized measure of verbal behavior in response to a wide variety of interpersonal situations commonly faced by health professionals. It contains 13 patient situations and requires 15 minutes for completion. Scoring of the audiotaped responses is based on BTIS scoring guidelines (See Gerard, B. & Buzzell, M (1980). User's manual for the behavioral test of interpesonal skills for health processionals. Reston, VA: Reston.) The subject is seated in front of a TV and as the TV plays each of the recorded situations; the subject makes a verbal response to the situation as though interacting with a real person. The responses are audiotape and then scored.

EMPATHY (EB/EM) 4.0

Barret-Lennard Relationship Inventory (BLRI)

RELIABILITY: Has shown high levels of reliability (r = .64 - .92).

VALIDITY: Nine studies have demonstrated internal reliability coefficients consistently exceeding intercorrelations among the BLRI subscales.

BACKGROUND: See Barrett-Lennard, G. (1981). The empathy cycle: Refinement of a nuclear concept. Journal of Counseling Psychology, 28(2), 99-91.

PURPOSE: Measures patient-perceived empathy.

WHERE TO FIND THE ARTICLE: Olson, J. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy and patient distress. IMAGE, 27(4), 317-322.

DESCRITPTION: The BLRI can be completed in 5 minutes. Consists of 16 statements of either an empathic or non-empathic clinician. Scores range from 48 to + 48.

EMPATHY (EB/EM) 4.0

Inventory of Socially Supportive Behaviors (ISSB)

RELIABILITY: Test-retest correlation coefficients for individual items ranged from 0.441 to 0.912. r (69) = 0.882, p< 0.001. Internal consistency (alpha) was first administration = 0.926; second = 0.940.

VALIDITY: Indices of social network size proved to be significant correlates of the ISSB. The ISSB is positively correlated with the Family Environment Scale (FES) Cohesion subscale.

BACKGROUND: Growing research interest in social support underscores the need for reliable and valid measures of the concept. It is argued that measures that assess what individuals actually do by way of providing support make unique contributions to our understanding of natural helping processes. See Barrera, M., Sandler, I.N. & Ramsey, T.B. (1981). Preliminary development of a scale of social support: Studies in college students. American Journal of Community Psychology, 9(4), 435-447.

PURPOSE: The ISSB was developed to evaluate how respondents reported the frequency with which they were the recipients of supportive actions.

WHERE TO FIND THE ARTICLE: Barrera, M., Sandler, I and Ramsey, T. (1981). Preliminary development of a scale of social supports of college students. American Journal of Community Psychology, 9 (4), 435-447.

DESCRITPTION: The ISSB is a 40 item scale rated on a 5 point likert scale ranging from 1 (not at all) to 5 (about every day).

EMPATHY (EB/EM) 4.0

Empathic Understanding in Interpersonal Processes (EUIPASM)

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The measure was developed by Carkhuff in conjunction with his work in operationalizing conceptual components of helping relationships.

PURPOSE: To measure empathy as a component of a helping relationship.

WHERE TO FIND THE ARTICLE: Henderson, M. (1987). Effect of empathy training on moral reasoning and empathic responding of nursing students. Doctoral dissertation: Auburn University.

DESCRITPTION: EUIPASM is a five-point scale of empathic understanding reflected in the counselor's response to helpee or client statements. A level -1 response communicates no awareness of the helpee's feelings. A level-2 response shows awareness of obvious feelings expressed by the helpee. A level -3 response is "accurate empathy" in which the expressions of the first person are interchangeable with those of the seemed person in that they express essentially the same affect & meaning. Level-3 is considered the minimal level of empathy necessary for therapeutic change to occur. A level 4 response communicates accurate empathy plus a deeper level of feeling. A level-5 response communicates full awareness of the helpee's experience, comprehensive understanding of that experiental reality, and total acceptance of the person.

Ethical Behaviors

HUMANISTIC (EB/HUM) 5.0

Scale of Humanistic Nursing Behaviors

RELIABILITY: 1. For 70-item scale, subscale reliabilities are as follows:

- 26 items, shared decision making, alpha = 0.89
- 25 items, holistic selves, alpha = 0.88
- 2 items, status equality, alpha = 0.83
- 7 items, empathy, alpha = .60

2. Test-Retest Reliability: 0.85; 16 subjects, 2-week interval.

VALIDITY: Construct validity was established by a purposive sampling of 42 nurses. For the 70 item scale: Criterion-Related Validity: Sig. F (<. 001) for each dimension determined, additional test supportive.

BACKGROUND: Based on Howard's (1975) theoretical model of dimensions pertinent to the domain of humanistic care. The Scale of Humanistic Nursing Behaviors can be used as a diagnostic aid and as an instructional device.

PURPOSE: Measures the degree of humanistic health care in hospital settings as perceived by nursing personnel.

WHERE TO FIND THE ARTICLE: Fenton, M. (1986). Development of the scale of humanistic nursing behaviors. Nursing Research, 36(2), 82-87.

DESCRITPTION: A list of 192 statements describing patient and nursing staff behaviors that occur on nursing units was initially developed. The scale, consist of 163 items, was developed and scored in a 5 point Likert format ranging from 1 to 5. The scale was reduced to 70 items measuring four dimensions: shared decision making and responsibility, holistic selves, status equality, and empathy.

RECIPROCITY (EB/R) 6.0

Caregiver Reciprocity Scale (CRS)

RELIABILITY: All factors were shown to be reliable by Cronbach's alpha.

VALIDITY: Content validity was established using exploratory and confirmatory factor analysis. Initial construct validity was established using exploratory factor analysis. The casual modeling approach was used to establish convergent and discriminate validity.

BACKGROUND: To develop the initial item pool, an extensive review of the literature was conducted. In addition, interviews were conducted with 12 adults, the children or in-laws of elderly parents, in their home environments. The interviews were transcribed and analyzed. One hundred nine items were developed to reflect exchanges within the caregiver context and/or among family members directly or indirectly involved in caregiving.

PURPOSE: Measures the collective expression of exchanges and balance in transactions between the caregiver and an elderly patient or parent-in-law, as well as within the family network.

WHERE TO FIND THE ARTICLE: Carruth, A. (1996). Development and testing of the Caregiver Reciprocity Scale. Nursing Research, 45(2), 92-97.

DESCRITPTION: The CRS is constructed as a five point Likert format ranging from 1 (strongly disagree) to five (strongly agree). Caregiver Information Sheet is used to collect data pertaining to demographic data, illnesses/conditions, and exchanges given to and received from care reciprocity.

Ethical Behaviors

SELF-DETERMINING (EB/SD) 7.0

Perceived Enactment of Autonomy (PEA Scale)

RELIABILITY: CronbachÕs alpha coefficient and principal component factor analysis followed by varimax orthogonal rotation were used to identify factors and items for the final PEA scale. CronbachÕs alpha = .87. Reliability established by internal consistency (CronbachÕs alpha of .85 for the 31 items); as well as content (CVI=. 86).

VALIDITY: Content & face validity established by panel of experts and the pilot survey. Construct validity obtained by testing theoretical relationships between PEA & perceived control (r = .52, p=<. 001), and between PEA & morale (r = .56, p<. 001).

BACKGROUND: Perceived enactment of autonomy (PEA) is sensing the ability to choose course of action for one's self in accordance with one's goals to meet needs for both dependence and independence. PEA represents the potential for self-care action and conceptually links self-care knowledge, resources, and action in Modeling and Role-Modeling (Erickson, Tomlin and Swain, 1988).

PURPOSE: Measures a person's perception of their ability to enact self-determined behavior.

WHERE TO FIND THE ARTICLE: Hertz, J. (1991). The Perceived enactment of autonomy scale: Measuring the Potential for Self-Care Action in the Elderly. Dissertation: University of Texas at Austin.

DESCRITPTION: The PEA scale consists of 31 short phrased questions (8 factors) scored on a 4 point Likert Scale ranging from 1 = not at all true to 4 = completely true. Scores range from 31 - 124 for total scale.

Ethical Behaviors

SELF-DETERMINING (EB/SD) 7.0

Competency Interview Schedule (CIS)

RELIABILITY: Inter-item correlation coefficients ranged from 0.39 to 0.85. The average correlation between items was 0.64. Item correlation with the total test score ranged form 0.69 to 0.89. Cronbach's coefficient alpha was 0.96.

VALIDITY: Uncertain. Examination of individual item score form CIS indicated that, in some cases, a different standard of competence was applied in routine clinical practice depending upon the patient's treatment decision.

BACKGROUND: The instrument was developed from initial work on the competency of patients to consent to hospital admission. The original formulation was revised and extended into the CIS for use with psychiatric patients referred for ECT.

PURPOSE: To compare physicians' judgments of patient competency in routine clinical practice with findings from a structured clinical interview.

WHERE TO FIND THE ARTICLE:

1) Bean, G., Nishisato, S., Rector, N. and Glancy, G. (1996). The assess ment of competence to make a treatment decision: An empirical approach. Canadian Journal of Psychiatry, 41, 85-92.

2) Bean, G., Nishisato, S., Rector, N. and Glancy, G. (1994). The psychometric properties of the competency interview schedule. Canadian Journal of Psychiatry, 39, 368-376.

DESCRITPTION: The CIS is a fifteen-item instrument, which incorporates 4 major elements to be considered when evaluating competency: Ability to make a firm treatment decision; understanding of treatment information; ability to make a choice based upon rational reasons; and, appreciation of the nature of the situation. Each element is assessed by a series of questions rated on a 7 point Likert scale ranging: 1-3 = adequate, 4 = marginal, 5-7 = inadequate.

TRUTHTELLING (EB/TR) 8.0

Truthtelling Interview Schedule

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The interview schedule was made available to the researcher by Dr. Carol Gilligan. The researcher revised the interview schedule and used a coding scheme developed by the researcher.

PURPOSE: To explore the behavior of nurses when faced with clinical situations which required them to choose one or more behaviors on a continuum of total honesty (fully informing clients) to fully deceiving clients (upholding the physician's plan).

WHERE TO FIND THE ARTICLE: Shipps, T.B. (1988). Truth telling behavior of nurses: what nurses' do when physicians deceive clients. Dissertation: Boston University.

DESCRITPTION: The interview asks the respondent to recall a real-life dilemma from experience. The interview presents four hypothetical dilemmas: Placebo, Informed Consent, Negligence and Withheld Information. Truthtelling dilemmas were evaluated using the interview schedule.

Ethical Behaviors

UNETHICAL (EB/UETH) 9.0

Unethical Teaching Behaviors Tool

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: Conceptually based on statements from the AAUP Statement on Professional Ethics which deals with the professor's ethical obligations as a teacher.

PURPOSE: To identify nursing students' perceptions of unethical teaching behaviors.

WHERE TO FIND THE ARTICLE: Theis, E. C. (1998). Nursing studentsÕ perspectives of unethical teaching behaviors. Journal of Nursing Education, 27(3), 102-106.

DESCRITPTION: Unstructured, open - ended questions. Subjects were asked to describe examples of teaching behaviors they encountered as nursing students, which they considered to be unethical. The behaviors could occur in classroom, non-classroom, or clinical settings.

Ethical Problems

ETHICAL ISSUES 1.0

Ethical Issue Scale (EIS)

RELIABILITY: End -of -life treatment issues scale =. 86 (Cronbach's alpha coefficient); patient care issues scale = .84; human rights scale = .74. Can be used as independent scales.

VALIDITY: Confirmatory principal components analysis of all items yielded a 3-component solution accounting for a total of 42.4% of initially extracted common variance.

BACKGROUND: The EIS was developed from a 32-item scale used in a 1994 study of Maryland nurses. The items of the original scale were derived from the literature & focus groups interviews of practicing nurses.

PURPOSE: To measure the frequency by which ethical issues occur in nursing.

WHERE TO FIND THE ARTICLE: Fry, S. T. & Duffy, M. E. (2001, in press). Development and psychometric evaluation of the Ethical Issue Scale (EIS). Image: Journal of Nursing Scholarship.

DESCRITPTION: Thirty two (32) item scale that represents three conceptual categories of ethical issues: end-of-life treatments (n=13), patient care (n=14), human rights (n=5).

Ethical Problems

ETHICAL ISSUES 1.0

Moral Problems

BACKGROUND: There is little to no existing research about actual moral dilemmas faced by nurses. Those studies that have been done have focused on medical ethics, not specifically nursing ethics. This deficit in research was discovered as the Netherlands worked to make nursing a more viable and respected profession.

PURPOSE: To answer the question: "What issues are experienced as moral problems by nurses in different settings and healthcare institutions and how serious are these moral problems for them?"

WHERE TO FIND THE ARTICLE: Arend, A. & Hurk, C. (1999). Moral problems among Dutch nurses: A survey. *Nursing Ethics*, 6(6), 468-82.

DESCRITPTION: It is a questionnaire that includes several demographic questions and other information about the respondent. The next section contains six types of problems that are graded on seriousness on a scale of 1 to 10. The last two sections consist of a list of situations; first the respondents are asked if these ate situations that they recognize as moral dilemmas. They are then asked to identify how often they have experienced them.

Ethical Problems

ETHICAL ISSUES 1.0

ICU and Ethics

RELIABILITY: Slightly skewed

VALIDITY: Before being used this questionnaire was pilot tested and then put before a review board containing nurse ethicists, research specialists and doctoral and masters students.

BACKGROUND: Most of the studies that have been done on assisted suicide in a hospital setting have focused on the physicians role, not that of the nurse.

PURPOSE: To learn about beliefs and ethical concerns of nurses caring for dying patients in intensive care units.

WHERE TO FIND THE ARTICLE: Puntillo, K., Benner, P., Drought, T., Drew, B., Stotts, N., Stannard, D., Rushton, C., Scanlon, C., & White, S. (2001). End-of-life issues in intensive care units: A national random survey nurses' knowledge and beliefs. American Journal of Critical Care, 10(4), 216-29.

DESCRITPTION: This tool is a questionnaire that contains three sections. The first is a series of clinical scenarios; the respondents are asked to identify the action taken by the nurse using one of five responses. They are also asked to identify whether or not they agreed with the action taken. A Likert scale is used in the second section to evaluate knowledge and opinion about pain management and end-of-life practices. The final section asks for demographics about the respondent. Overall, the questionnaire contains 61 questions as well as space for additional comments.

Ethical Problems

EUTHANASIA/ASSISTED SUICIDE (EP/EAS) 2.0

Assisted Suicide & Patient Requested Euthanasia Tool

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The study was a replication and extension of Emanual's 1994 survey of New England oncology physicians. The study was conducted to provide reliable and valid empirical data to New England ONS members practices of assisted suicide and patient-requested euthanasia. Analysis focused on nurses' practices, a comparison to a like sample of oncology physicians, and the nurses' utilization of the health-care team.

PURPOSE: To determine oncology nurses' practices and attitudes toward patient requested euthanasia and assisted suicide.

WHERE TO FIND THE ARTICLE: Matzo, M. and Emanual, E. (1997). Oncology nurses' practices of assisted suicide and patient-requested euthanasia. Oncology Nurses' Forum, 24 (10), 1725-1732.

DESCRITPTION: Questionnaire of 63 questions. Twenty-two questions involved four clinical vignettes regarding personal experiences with assisted and patient requested euthanasia in clinical practice.

Ethical Problems

LIFE SUPPORT (EP/LS) 3.0

Advance Directive Questionnaire

RELIABILITY: Not provided.

VALIDITY: Content validity was assessed by a panel of experts.

BACKGROUND: The individual's right to refuse life-prolonging treatments was the impetus for the initiation of the Patient Self-Determination Act (PSDA), which became effective in 1992. Although living wills have been in existence for years, it has only been since the PSDA legislation that most nurses have had to assume a major role in collecting information and operationalizing advance directives.

PURPOSE: To determine nurses' experience, confidence in counseling, and knowledge of state law concerning advance directives (AD).

WHERE TO FIND THE ARTICLE: Barta, K. and Neighbors, M. (1993). Nurses' knowledge of and role in patients' end-of-life decision-making. Trends in Health Care, Law, & Ethics, 8 (4), 50-52.

DESCRITPTION: Three page, four-part questionnaire developed from literature & federal / state (Arkansas) legislation. Part I: nurse's experience with Ads; Part II: True/False; nurse's knowledge of state law content on AD; Part III: nurse's inclusion of ANA guidelines in nursing assessments; & Part IV: 4 point Likert scale ranging from 1 = not at all confident to 4 = very confident; nurse's perception of self-confidence regarding counseling patients/families about AD.

Ethical Problems

LIFE SUPPORT (EP/LS) 3.0

Life Support Preferences Questionnaire (LSPQ)

RELIABILITY: Consistency of responses ranged from 0.772 to 0.947; average consistency was 0.85.

VALIDITY: Covariation 0.77. Internal consistency for the single factor solution was estimated at 0.94. The nurses and one doctorally prepared nurse researcher were asked to act as expert judges and review the revised vignettes for face validity and content sampling.

BACKGROUND: The Patient Self-Determination Act, effective since December, 1991, has changed the importance of introducing life support options to patients. Nurses, as patient advocates, are in the forefront of presenting life support information.

PURPOSE: This tool is designed to gently introduce the topic of life support decision making and options to patients. If educates patients and their families about the array of life support choices beyond the NR an mechanical ventilation options.

WHERE TO FIND THE ARTICLE: Beland, D. and Froman, R. (1995). Preliminary validation of a measure of life support preferences. IMAGE, 27 (4), 307-310.

DESCRITPTION: The LSPQ is a rapid, easy to use instrument that provides illustrations of life support choices to enhance discussion of life support measures with patients. It consists of six vignettes with two choices following each vignette.

Ethical Problems

LIFE SUPPORT (EP/LS) 3.0

Survey of Implementation and Impact of (PSDA)

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The PSDA became effective in December 1991 and mandates that patients be given information about legal rights regarding living wills and durable powers of attorney for health care. This study investigated the impact of this law on hospitals, medical personnel and patients. Despite recognition of the importance of implementation of the PSDA, little is known about what institutions are actually doing.

PURPOSE: Measures different aspects of the PSDA: (a) hospital personnel's development of awareness and information-gathering procedures, (b) the hospital's present procedures for implementing the law; (c) the individual respondent's personal knowledge and interpretation of the law; (d) the perceived effect of the PSDA with respect to completion of advance directives; and, (e) hospital personnel's attitudes and opinions about the law.

WHERE TO FIND THE ARTICLE: Park, D., Eaton, R., Larson, E., and Palmer, H. (1994). Implementation and impact of the patient self-determination act. Southern Medical Journal, 87 (10), 971-977.

DESCRITPTION: The survey instrument consisted of 60 questions that were printed in a booklet and mailed to hospital administrators. All but 17 items were forced choice (true or false).

MORAL DISTRESS (EP/MD) 4.0

Moral Distress Scale

RELIABILITY: Test-rest reliability was r=. 86 (P <. .01). When identical forms were administered three weeks apart to 35 RNs, Cronbach's alpha was .93 (P<< .01).

VALIDITY: Content validity was established through 100% agreement on the content validity index by three nursing ethics experts. Factors analysis using a varimax rotation yielded three theoretically meaningful factors: (1) action response (14 items); (2) aggressive care (9 items); and (3) honesty (8 items). There were low significant correlations between the factors.

BACKGROUND: This instrument was used in the study of moral distress of critical care nurses. After initial testing, the scale was extended from 5 to 7 points to increase variability in responses. The tool is based on Jameton's concept of moral distress and Wilkinson's results from a study of moral distress.

PURPOSE: Measures nurses' perceptions of level of moral distress and frequency of situation.

WHERE TO FIND THE ARTICLE: Corley, M. (1993). Moral distress of critical cares nurses. American Journal of Critical Care, 4 (4), 280-285.

DESCRITPTION: The Moral Distress Scale is a 32 item scale scored on a 7 point Likert scale ranging from 1 = low to 7 = high.

Ethical Problems

PAIN (EP/P) 5.0

The Barriers Questionnaire (BQ)

RELIABILITY: Researchers claim that "the BQ has acceptable reliability "Test-retest reliability .90 Internal consistency of 0.89 for the entire scale and 0.52 to 0.91 for the sub scales.

VALIDITY: Researchers claim that "the BQ has acceptable validity" No further information is provided.

BACKGROUND: The purpose of this study was to examine concerns about reporting pain and using analgesics in a sample of primary care givers of cancer patients receiving care from a hospice program.

PURPOSE: Measures eight common barriers to adequate management of cancer pain.

WHERE TO FIND THE ARTICLE: Berry, P. and Ward, S. (1995). Barriers to pain management in hospice: a study of family caregivers. The Hospice Journal, 10 (4), 19-33.

DESCRITPTION: The BQ is a 27 item self-report instrument diagnosed to measure the extent to which persons have eight concerns about reporting pain and using analgesics. The 27 items are scored on a 6 point Likert types scale ranging from 0 = do not agree at all to 5 = agree very much. The eight concerns are fear of opiod side effects fear of addiction. The belief that increasing pain signifies disease progression, fear of injections, concern about drug tolerant, believing "good" patients do not complain about pain. The belief that reporting pain may distract the physician from treating or curing the Cancer and fatalism, or believing pain is inevitable with cancer and that is co not be relieved.

Ethical Problems

PHYSICAL RESTRAINT USE (EP/PR) 6.0

Revised Restraint Questionnaire

RELIABILITY: Internal consistency of the 15 item practice scale and the 11 item attitudinal scale was 0.76 and 0.49 respectively. Item total correlation were recalculated for each scale and items with the lowest squared multiple correlation's were deleted. The revised 12 item practice scale and 8 item attitude scale had a CronbachÕs alpha of 0.78 (standardized item alpha of 0.82) and 0.63 (standardized item alpha of 0.64) respectively.

VALIDITY: Internal consistency of the 15 item practice scale and the 11 item attitudinal scale was 0.76 and 0.49 respectively. Item total correlation were recalculated for each scale and items with the lowest squared multiple correlation's were deleted. The revised 12 item practice scale and 8 item attitude scale had a CronbachÕs alpha of 0.78 (standardized item alpha of 0.82) and 0.63 (standardized item alpha of 0.64) respectively.

BACKGROUND: Specific aims: to describe nurses' knowledge, practice and attitudes about the use of physical restraints in this population; and, to determine whether demographic characteristics or the hospital practice setting influence nurses' knowledge, practice, attitudes regarding the use of physical restraints with older patients. Cross-sectional descriptive study.

PURPOSE: Identifies issues related to the use of physical restraints with older patients in hospital settings.

WHERE TO FIND THE ARTICLE: Matthiesen, V., Lamb, K., McCann, J., Hollinger-Smith, L. and Walton, J. (1996). Hospital nurses' views about physical restraint use with older patients. Journal of Gerontological Nursing, 22 (6), 8-16.

DESCRITPTION: 20 item true/false scale with 3 subscales: knowledge about physical restraints, clinical practice issues related to physical restraints, attitudes toward using physical restraints.

Ethical Problems

PHYSICAL RESTRAINT USE (EP/PR) 6.0

Knowledge and Ethics of Restraint

RELIABILITY: Twenty-three nurses tested the questions for relevance, reliability and repetition.

VALIDITY: The shortcomings of this questionnaire are that it only deals with physical restraints and dementia patients. There is no mention of chemical restraints or of non-dementia elderly. There is also no way to know for sure if what the nurses answered is what they actually practice.

BACKGROUND: The number of dementia patients in Israel is on the rise, as the population grows older. This increase puts a strain on nurses who are not used to dealing with such patients. However, there has been little to no research done on physical restraint use with dementia patients.

PURPOSE: To compare the ethical dilemmas faced by nurses in hospitals and psychogeriatric wards of nursing homes in using physical restraints on dementia patients. Also, to obtain information about the knowledge of nurses about patients' rights laws, the Israeli Code of Ethics and guidelines on restraint.

WHERE TO FIND THE ARTICLE: Weiner, C., Tabak, N. & Bergman, R. (2003). The use of physical restraints for patients suffering from dementia. Nursing Ethics, 10(5), 512-25.

DESCRITPTION: This is a three-part questionnaire. The first part is demographic questions, including level of education and geriatric training. The second part consists of twenty-five items that test knowledge about the use of restraints. An answer of "yes" receives a score of one, an answer of "no' or "don't know" receives a score of zero. The third section is eighteen real-life episodes devised by nurses in both settings being tested. The scenarios are organized into three categories: to protect the patient, to protect the institution, and to protect other patients at the institution. The scenarios are rated on a scale of one to four as to how appropriate a response the nurse feels that restraints are.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Quality of Life Questionnaire

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: Data for the Quality of Life Study were obtained through personal interviews with 2,164 persons, 18 years & over living in households in the U.S., exclusive of households on military reservations, in 1971.

PURPOSE: To measure respondents' perception to their solid-psychological condition, their needs & expectations for life, & the degree to which these needs are satisfied.

WHERE TO FIND THE ARTICLE: Campbell A., Converse., P.E., & Rodgers, W.L. (1975). The Quality of American Life. The Institute for Social Research, Survey Research Center, University of Michigan.

DESCRITPTION: Sectional Questionnaire covering: City and neighborhood; housing; country; adjectives to describe life; education; employment; organizations, spare time and income; friendships; satisfaction with life; feelings about own life; background information; and observation of the respondent by the interviewer.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Quality of Life Self-Assessment - Cancer Patients

RELIABILITY: Test-retest: .97 for analogue scale and .72 for six point scale CronbachÕs coefficient alpha: .80 for total instrument; .90 for symptom distress and .70 for activities of daily living.

VALIDITY: Indirectly evaluated due to subjective feelings and difficulty in interpreting their depth; face validity: includes the items considered by the investigators and previous studies; content validity established by inclusion of items identified by investigators and supported by interviews; construct validity needs to be confirmed through future studies.

BACKGROUND: The need for a method by which to measure the quality of survival (QOL) is now increasingly recognized. This reflects a change on the part of members of the health care team as the value of cancer therapy is now judged not only on the duration of survival but also on its quality.

PURPOSE: To measure the quality of survival following treatment of a life threating illness. Specifically measures self-assessment of life changes that have resulted from the presence & treatment of malignant disease.

WHERE TO FIND THE ARTICLE: Holmes, S. and Dickerson, J (1987). The quality of life: design and evaluation of a self-assessment instrument for use with cancer patients. International Journal of Nursing Studies, 24, (1), 15-24.

DESCRITPTION: The questionnaire contains 11 symptoms statements and 15 ADLs statements arranged in a linear analogue scale format.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Quality of Life - Adults with Chronic Illnesses 3

RELIABILITY: no reliability data reported.

VALIDITY: factor analysis suggested construct validity.

BACKGROUND: Developed to identify the (a) terms that adults with chronic illnesses use to describe their quality of life (b) important domains that constitute QOL, and (c) self-perceived QOL by persons with chronic illness.

PURPOSE: Measures self-reported QOL.

WHERE TO FIND THE ARTICLE: Burckhardt, C., Woods, S. Schultz, A. and Ziebarth, D. (1989). Quality of life of adults with chronic illness: a psychometric study. Research in Nursing and Health, 12, 347-354.

DESCRITPTION: 15 item domain specific instrument rated on a 7 point Likert scale ranging from 1 = unhappy and terrible to 7 = delighted. Domains: material comforts, health, relationships with relatives, having & rearing children, close partner, close friends, helping/encouraging others, organizations, learning, understanding self, work, expressing self creatively, socializing with others, reading, music or watching entertainment, and participating in active recreation.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Perceptual Quality of Life Interview / Questionnaire

RELIABILITY: No information provided.

VALIDITY: No information provided.

BACKGROUND: The treatment of cancer has resulted in an increased awareness of the need to evaluate outcome not only in terms of care & survival but also in terms of quality of life.

PURPOSE: Measures quality of life both in objective and subjective terms of cancer patients.

WHERE TO FIND THE ARTICLE: Danoff, B., Kramer, S., Irwin, P. and Gottlieb, A. (1983). Assessment of the quality of life in long-term survivors after definitive radiotherapy. American Journal of Clinical Oncology, 6, 339-345.

DESCRITPTION: An interview questionnaire was developed which contained both objective as well as subjective measures of quality of life. The questionnaire consists of four sections: descriptive demographic items, medical data, perceptual quality of life questions and health status questions. The patient was asked to rate his feelings about each of the 41 QOL items on a 7-point scale that ranged from 1 = delighted to 7 = terrible. The perceptual quality of life questions were selected from a series of national surveys on quality of life by Andrews & Withey (1976).

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Enforced Social Dependency Scale (ESDS)

RELIABILITY: Reliability coefficient alpha was 0.90 and the standardized-item alpha was 0.91.

VALIDITY: Content vadity was assessed by interviews of patients with life - threatening illness. Discrimmant Validity established by demonstrated ability to distinguish between situation in which recovery is likely verses not likely. Two factors were confirmed by factor analysis. Postine correlation with the Sickness Impact Profile, r= 0.89.

BACKGROUND: Social dependence was defined in terms of three capacities identified as necessary for the performance of an adult role: everyday self-care competence, mobility competence, and social competence.

PURPOSE: Measures extent to which patients require assistance from others in performing activities or roles that adults ordinarily can perform by themselves.

WHERE TO FIND THE ARTICLE: Benoliel, J., McCrokle, R. and Young, K. (1980). Development of a Social Dependency Scale. Research in Nursing and Health, 3, 3-10.

DESCRITPTION: The instrument consists of 12, 6 -point scales (4 for each capacity). Scores are computed for each capacity (range 4-24) and for all three capacities together (range 12-72). Higher scores representing a great deal of social dependency and lower scores representing little social dependency.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

McMaster Quality of Life Scale(MQLS)

RELIABILITY: Interrater and intrarater reliability was examined using repeated measures ANOVA; inter rater reliability was lower than intra rater reliability. Internal consistency: overall alpha was 0.80.

VALIDITY: Construct validity were examined using a t--test for the two a priori hypotheses: p = 0.04: Concurrent validity was correlated to be statistically significant with the Spitzer index.

BACKGROUND: Quality of life assessment has been suggested as the best method for determining the effectiveness of various approaches to palliative care.

PURPOSE: Measures quality of life.

WHERE TO FIND THE ARTICLE: Sterkenburg, C., King, B., and Woodward, C. (1996). A reliability and validity study of the McMaster Quality of Life Scale (MQLS) for a palliative population. Journal of Palliative Care, 12 (1), 18-25.

DESCRITPTION: The McMaster Quality of Life Scale taps four dimensions of quality of life: physical, emotional, social and spiritual. It contains 32 items rated on a 7 point numerical scale ranging from negative descriptors to positive descriptors.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Sickness Impact Profile (SIP)

RELIABILITY: The SIP'S test-retest reliability was reported by Pollard and associates (1976). After a 24-hour interval, the correlation between the test-retest situation was .88 (p< .01). Several other combinations of teat-retest procedures were undertaken (e.g., long form versus short form; interviews administered versus self-administered); all combinations of these different conditions had correlations that were significant at p< .01. In addition, test-retest reliability correlation for each of the 12 dimensions are of the same magnitude of significance.

VALIDITY: The item pool was selected from responses by "over 1000" persons who mentioned 1.250 specific dysfunctions of behavioral changes that were related to health (Gilson et al., 1975. p. 1307). By various grouping and testing procedures, this list was reduced to the current number of items. Various experiments related to the validity of the instrument were reported by Bergner, Bobbitt, Pollard, Martin and Gilson (1976). The successful (p< .001) tests of validity indicated that the SIP percentage score correlates with self-assessment of sickness (r = .54), self-assessment of dysfunction (r = .52); the Activities of Daily Living Index (Spearman rank-order correlation = .46), a clinical assessment of dysfunction (r = .49) and the activity limitation question ion the National Health Interview Survey (r = .61).

BACKGROUND: Although the need for a method of measuring the quality of life of patients undergoing therapy for cancer has been widely recognized, no adequately evaluated or feasible method has been established. Thus the SIP was developed as an outcome measure of overall health as a consequence of the use of the health-care delivery system.

PURPOSE: To measure outcomes of contact with the health care delivery system; also, to measure health status based on functioning.

QUALITY OF LIFE (EP/QOL) 7.0

Sickness Impact Profile (SIP)

WHERE TO FIND THE ARTICLE: Selby, P., Chapman, A., Etazadi-Amoli, J., Dalley, D. and Boyd, N. (1984). The development of a method for assessing the quality of life of cancer patients. British Journal of Cancer, 50, 13-22.

DESCRITPTION: The Sickness Impact Profile contains 136 items grouped into 12 dimensions of daily activity; sleep and rest, emotional behavior, body care & movement, home management, mobility, social interaction, ambulation, alertness behavior communication, work, recreation & pastimes, and eating. Respondents check those items that apply to them at the time of the interview.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Quality of life Survey (QLS)

RELIABILITY: Test-retest reliability: r = 0.60
Internal consistency: CronbachÕs alpha: total = 0.82; sub scales: symptoms = 0.63; social concerns = 0.68; psychological well-being = 0.62; and, physical well-being = 0.72.

VALIDITY: Construct validity: F = 36,1; p = 0.001
Content validity: CVI = 0.90
Construct validity: 9 factors via factor analysis.

BACKGROUND: The tool is modeled after the QOL instrument tested by Padilla & Grant (1985) & Padilla, et. Al. (1983).

PURPOSE: Measures quality of life.

WHERE TO FIND THE ARTICLE: Ferrell, B., Wisdom, C., Wenzl, C. and Brown, J. (1989). Effects of controlled release morphine on quality of life for cancer patients. Oncology Nursing Forum, 16 (4), 521-526.

DESCRITPTION: The Quality of Life survey is a multidimensional 100 mm analogue scale with word extremes as anchors at the end of each scale. Items for the 28-item survey represented the areas of psychological well being, physical well being, general symptom control, specific symptom control, and social support.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Quality of Well Being Scale (QWB)

RELIABILITY: Reported in: Kaplan, R.M. & Anderson, J. P. (1988). The quality of well-being scale! Rationale for a single quality of life index. In Walkee, S. R. & Rosser, R. (EDS). Quality of Life: Assessment and Application, London, MTP PRESS, p.p. 51-77.

VALIDITY: See above.

BACKGROUND: QWB scores are derived from preference weight s for combinations of symptom/problem complexes and classification of functioning in terms of mobility, physical activity, and social activity obtained form a San Diego general population sample of 867 individuals. These preference weights were obtained in the mid 1970s but a 1991 study of Oregon citizens yielded very similar results.

PURPOSE: To provide an estimate of the value of health status necessary for cost-utility analyses. Also, to quantify health-related quality of life with a single number that represents community-based preferences for combinations of symptom/problem complexes, mobility, physical activity, and social activity.

WHERE TO FIND THE ARTICLE: Hays, R., Siu, A., Keeler, E., Marshall, G., Kaplan, R., Simmons, S., El Mouchi, D. and Schnelle, J. (1996). Long term care residents' preferences on the QWB scale. Medical Decision-Making, 16 (3), 254-261.

DESCRITPTION: The QWB Scale identifies a health related symptom that is most undesirable and grades it by the degree to which it affects everyday activities. By using QWB assessment, a single number is developed that represents the current impact of disease.

QUALITY OF LIFE (EP/QOL) 7.0

Quality of Life Index (QLI)

RELIABILITY: Internal Consistency (CronbachÕs alpha) = 0.93 for the total scale and 0.87, 0.82, 0.90 and 0.77 for the sub scales.

VALIDITY: Construct validity was supported by the contrasted groups approach and factor analysis. Convergent validity was provided by a correlation of r = 0.77 between the QLI and an assessment of life satisfaction.

BACKGROUND: The instrument was developed to provide information about specific life domains in order to allow health care professionals to pin point problem areas, examine practices, and plan interventions to improve quality of life.

PURPOSE: Measures subjective satisfaction in with specific life domains; measures importance of domains to the subject.

WHERE TO FIND THE ARTICLE: Ferrans, C. and Powers, M. (1992). Psychometric assessment of quality of life index. Research in Nursing and Health, 15, 29-38.

DESCRITPTION: Tool consists of 64 items, 2 parts: Part I: measures satisfaction with various domains of life on a 6 point Likert scale ranging from 1 = very satisfied to 6 = very dissatisfied; Part II: measures importance of the same domains to the individual on a 6 point Likert scale ranging from 1 = very unimportant to 6 = very important. The domains of life measured include, (1) health and functioning, (2) Socioleconomic status. (3) Psychological/spiritual status, and (4) family relationships.

QUALITY OF LIFE (EP/QOL) 7.0

Symptom Distress Scale

RELIABILITY: Reliability coefficient = 0.82143
Alpha coefficient = 0.82557.

VALIDITY: Correlations were found to be positive.

BACKGROUND: Not Known.

PURPOSE: Measures symptom distress of patients.

WHERE TO FIND THE ARTICLE: McCorkle, R. and Young, K. (1978). Development of a symptom distress scale. Cancer Nursing, 373-378.

DESCRITPTION: Ten symptoms are evaluated (nausea, appetite, pain, fatigue, bowel patterns, concentration, appearance, breathing, outlook, & cough). Five by seven cards with a single symptom were prepared. Patients rated their symptoms on a given day from 1 (least distress) to 5 (most distress) on the cards.

Ethical Problems

QUALITY OF LIFE (EP/QOL) 7.0

Quality of Life Cancer Scale (QOV-CA)

RELIABILITY: Internal consistency alphas for QOL - CA range from .52 to .88 total alpha is 0.91.

VALIDITY: Construct validity & convergent construct validity is established. Factor analysis yielded 5 factors.

BACKGROUND: The multi-dimensional quality of life scale for use with persons with cancer evolved form a need for a single, short, easy to administer, reliable and valid, graphic measure of well being in persons with cancer. QOL; was originally defined as a personal, subjective e valuation of physical and psychological well being and symptom distress.

PURPOSE: To measure the quality of life of cancer patients.

WHERE TO FIND THE ARTICLE: Padilla, G., Presant, C., Grant, M., Metter, G., Lipsett, J. and Heide, F. (1983). Quality of life index for patients with cancer. Research in Nursing and Health, 6, 117-126., also Padilla, G. V., Miskel, M H., & Grant, M. M. (1992). Urtainty, appraisal, and quality of life. Quality of Life Research, 1(3), 155-165.

DESCRITPTION: In the original tool, QOL was measured on 14 linear analogue scale items scored from 0 - 100 in increments of 10. Average QOL score is 14. Items assess physical condition, normal activities, and personal attitudes on general quality of life. I n the QOL - CA tool, QOL is measured by 30 times that assess (1) psychological existential well-being, (2) physical/functions well-being, (3) symptoms distress & nutritum, (4) symptom distress & pain/bowel pattern, and (%) attitude of worry.

QUALITY OF LIFE (EP/QOL) 7.0

MOS Short Form

RELIABILITY: Reliability coefficients ranged from 0.81 to 0.88 for the multi-item scale. Internal consistency reliabilities were lower that the full length versions: health perception subscale = 0.87 (0.88 for 9 item version); mental health measure subscale = 0.88 (0.96 for the 38 item version); physical function subscale = 0.86 (0.90 for the 10 item version); role subscale = 0.81 (0.92 for the 3 item version).

VALIDITY: All correlation's were statistically significant: $p < 0.01$ and most were substantial in magnitude

BACKGROUND: Research showed that the McMaster Health Index, Sickness Impact Profile, Functional Status Questionnaire, Duck-UNC Health Profile, RAND Health Experience Measures, Nottingham Health Profile and Index of Well Being were instruments too long to be practical in most clinical settings. Thus, a compromise between lengthy instruments and single-item measures was sought. Twenty items were selected to represents six health concepts: (1) physical functioning, (2) role functioning, (3) social functioning, (4) mental health, (5) health Perceptions, and (6) pain.

PURPOSE: To measure general health concepts for use in evaluating health care.

WHERE TO FIND THE ARTICLE: Stewart A., Hays, R. and Ware, J. (1988). The MOS Short Form General Health Survey. Medical Care, 26 (7), 724-732.

DESCRITPTION: The MOS-Short form is a 20-item scale. Items are scored on a 5 point Likert Scale.

Moral Reasoning

GENERAL (MR/G) 1.0

Responses to DNR orders in the NICU

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: Based on prior work by Ajzen and Fishbein's theory of reasoned action.

PURPOSE: Elicits nurses' attitudes, subjective norms and behavioral intent with respect to DNR orders in neonatal intensive care units.

WHERE TO FIND THE ARTICLE: Savage, T.A., Cullen, D.L., Kirchoff, K.T., Pugh, E.J. & Foreman, M.D. (1987). Nurses responses to do-not-resuscitate orders in the neonatal intensive care unit. Nursing Research, 36, 370-373.

DESCRITPTION: Three part fixed response questionnaire: Part I: items ascertain nurses' awareness of hospital DNR policy, experiences with DNR situations and beliefs about who should make DNR decisions; Part II: tests nurses' attitudes, subjective norms and behavioral intentions toward compliance using hypothetical situations and scale responses; Part III: collects demographic data.

Moral Reasoning

GENERAL (MR/G) 1.0

Defining Issues Test (DIT-1 A & DIT-2)

RELIABILITY: Cronbach's alpha is in the upper .70s/low .80s. Test - retest is about the same.

VALIDITY: Has been assessed in terms of seven criteria over fifteen years. DIT scores show discriminant validity from verbal ability/ general intelligence and from conservative/liberal political attitudes.

BACKGROUND: The DIT is a multiple - choice, objective, and self- administered test derived form Kohlberg's Theory of moral development. It has been extensively tested and is now available in a new version, DIT - 2.

PURPOSE: Measures how people reason morally about social problems.

WHERE TO FIND THE ARTICLE: Rest, J., Narvaez, D., Bebeau, M. J. & Thomas, S. J. (1998). Postconventional moral Thinking: A Neo-kohlbergian Approach.

DESCRITPTION: DIT - 1 contains six vignettes followed by multiple choice questions addressing recommended action and prioritization of items. DIT - 2 consists of five dilemmas that represent modern social problems. The DIT - 1 Short form consists of just the first three dilemmas of the DIT - 1.

Moral Reasoning

GENERAL (MR/G) 1.0

Nursing Dilemma Test (NDT)

RELIABILITY: Coefficient alpha = .57 for principled missing consideration.

VALIDITY: Significant differences demonstrated among nurses with different educational preparation in principled nursing considerations ($F = 3.37$, $p < .001$). Where those with higher education scored higher and those with lower. There is a significant correlation between the DiT and NDT ($p < .001$).

BACKGROUND: Uses the DIT as its paradigm and measures a cognitive process, moral judgment.

PURPOSE: Measures moral reasoning in nursing situations.

WHERE TO FIND THE ARTICLE: Crisham, P. (1979). Measuring moral judgment in nursing dilemmas: Nursing Research, 30(2), 104-110.

DESCRITPTION: Tool contains six vignettes, each followed by three sections of objective questions asking participant to indicate what she/he would do in the situation, to rank six statements about relevant issues from most to least important, and to rate the extent of her/his previous involvement with similar dilemmas.

Moral Reasoning

GENERAL (MR/G) 1.0

Ethical Behavior Inventory

RELIABILITY: Point biserial for each of the items was .40 or above. Haytis reliability with the total test (RH)= .93.

VALIDITY: Content validity determined by experts.

BACKGROUND: Based on Crisham's scenarios that were not included in the NDT.

PURPOSE: Measures nurses' self-reported behaviors.

WHERE TO FIND THE ARTICLE: Cox, J. L. (1985/1986). Ethical decision making by hospital nurses. (Doctoral Dissertation, Wayne State University) Dissertation Abstracts International, 47, 131B.

DESCRITPTION: Six patient care vignettes followed by multiple choices questions with one choice congruent with the ANA Code for Nurses.

Moral Reasoning

GENERAL (MR/G) 1.0

Advocacy Assessment Tool

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: Client advocacy is an essential component of the professional role of the nurse, although relatively little is known about how this important concept is viewed by the average nurse.

PURPOSE: This tool measures models of advocacy used in nurses' ethical decisions.

WHERE TO FIND THE ARTICLE: Millete, B.(1993). Client advocacy and the Moral orientation of nurses. Western Journal of Nursing Research, 15(5), 607-618.

DESCRITPTION: The advocacy assessment questionnaire consists of three parts: Part I: order rank the three models of advocacy and indicate on a Likert-scale the degree of agreement or disagreement with the kind of advocacy. Part II: select and rank the three most favored and least favored responses to a written moral dilemma. Part III: Demographic information.

Moral Reasoning

HEALTH CARE (MR/HC) 2.0

Health Care Decision - Making Questionnaire (Nurses Version)

RELIABILITY: Not reported.

VALIDITY: Not reported.

BACKGROUND: The questionnaire is adapted from one used in a study of physicians, the results of which are reported by Self in 1983.

PURPOSE: To determine the philosophical positions held by nurses with respect to their ethical decisions, and their relationship to the subjective-objection controversy in Value Theory.

WHERE TO FIND THE ARTICLE: Self, Donnie J. (1987). A study of the foundation of ethical decision-making of nurses. Theoretical Medicine, 8: 85-95.

DESCRITPTION: The "nurse-version" of the tool is 9 questions. The questions are constructed so that three questions relate to each of three possible positions in the subjective-objective issue; i.e., subjectivism, partial-subjectivism-partial objectivism, and complete objectivism.

Moral Reasoning

PRINCIPLED ETHICS (MR/PE) 3.0

Values in the Choice of Treatment Inventory

RELIABILITY: Alpha reliability = patient sample: .69, dyad sample: .76.

VALIDITY: Correlation between the two scales for patients = .58, and for family sample = .64 ("moderately high").

BACKGROUND: Researchers used four ethical principles as the basis for values that would be held by patients & patients' families.

PURPOSE: To measure patients & family values in the choice of treatment, particularly in surgical treatment of cardiac disease.

WHERE TO FIND THE ARTICLE: Gortner, S. & Zyzanski, S. (1988). Values in the choice of treatment: Replication and refinement. Nursing Research, 37, 240-244.

DESCRITPTION: Sixteen items inventory, later refined to 12 items. 2 subscales: autonomy and beneficence. Items use Likert scale, 1 = strongly disagree, 4 = strongly agree. Instrument administered 4th - 6th postoperative day.

Moral Reasoning

PRINCIPLED ETHICS (MR/PE) 3.0

Ethical Reasoning in Terminal Care Interview

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: In the terminal phase of life, some cancer patients have problems eating. Caregivers then have to decide whether or not to provide the patients with food by artificial means. Taped interviews concerning treatment of terminally ill, mentally alert, old cancer patients who refused food were conducted with 20 RNs who were regarded as "experienced and good nurses."

PURPOSE: Identifies ethical reasoning in experienced registered nurses by an analysis of the conditions under which they think that terminally ill, mentally alert, old cancer patients who refuse food should be fed, whether they think active euthanasia should be used, how they explain their decision, and how they would rank order ethical principles and explain their ranking.

WHERE TO FIND THE ARTICLE: Jansson, L. & Norberg, A. (1989). Ethical reasoning concerning the feeding of terminally ill cancer patients: Interviews with registered nurses experienced in the care of cancer patients. Cancer Nursing, 12, 352-358.

DESCRITPTION: The interviewer asks the respondent their opinion on active euthanasia. The respondent ranks in order the ethical principles of autonomy, beneficence, justice, and sanctity of life for her professional as well as for her personal life, and explains how the ranking was determined.

Moral Reasoning

SOCIOMORAL REASONING (MR/SM) 4.0

Social Reflection Measure (SRM)

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The SRM is a paper and pencil written version of the original moral Judgment Interview (MJI) of Kohlberg.

PURPOSE: To measure moral reasoning.

WHERE TO FIND THE ARTICLE: Gibbs, J. and Widaman, K. (1982). Social Intelligence: Measuring the Development of Sociomoral Reflection, 191-211. Prentice-Hall: NJ.

DESCRITPTION: The SRM uses the same dileminas as the MJI but involves written responses rather than one-on-one oral tape-recorded responses. The SRM is group administrable.

Moral Reasoning

SOCIOMORAL REASONING (MR/SM) 4.0

Moral Judgment Interview: Kohlberg (MJI)

RELIABILITY: High alternative form reliability of up to 100% agreement on stage score has been reported.

VALIDITY: Subjects measured overtime more forward through the hypothesized stages of moral reasoning in an invariant sequence, supporting the construct of a develop mental sequence of moral reasoning.

BACKGROUND: The MJI was the original test developed by Kohlberg to measure the moral reasoning construct, and reflects his conceptualization of justice as the central core of morality. There are three forms of the MJI, each consisting of three dilemmas.

PURPOSE: To evaluate the moral judgment of persons using dilemmas.

WHERE TO FIND THE ARTICLE: Kohlberg, L. (1984). The psychology of moral development. Essays in Moral Development, II. Harper and Row: San Francisco.

DESCRITPTION: The MJI consists of a 45-minute semi structured oral tape-recorded interview in which subjects are asked to resolve a series of three moral dilemmas. Each dilemma is followed by a systematic set of open-ended probe questions designed to enable the subject to reveal the structure of logic of his or her responses. Scoring yields an overall score, which is a continuous measure of moral maturity; and a score that reflects the subjectÕs stage of moral reasoning.

Values and Attitudes

DEATH (V/A/D) 1.0

Threat Index- elicited form (TIE)

RELIABILITY: Coding system judged reliable using two independent judges.

VALIDITY: Not addressed.

BACKGROUND: This tool was developed to enable the content analysis of death related constructs as apposed to tools that measure the structure of elements within the construct.

PURPOSE: Provides clinically rich and personally relevant depiction of interviewee's construal of death; may facilitate psychotherapeutic exploration of client's death concern. The manual details the system for analyzing the content of constructs that person's employ to conceptualize situations involving death and dying.

WHERE TO FIND THE ARTICLE: Neimeyer, R., Epting, F. and Rigdon, M. (1984). A procedural manual for the Threat Index.

Neimeyer, R., Fontana, D. and Gold, K. (1984) A manual for content analysis of death constructs. both In, F. Eptin, g and R. Neimeyer (eds.), Personal Meanings of Death, 299-327. WA: Hemisphere Publishing Company.

DESCRITPTION: Structured 90 minute interview; individually administered. 9 situations are used involving death. The interviewee is provided with 3 "death" cards with the situations on them and is questioned as to their similarities and differences.

DEATH (V/A/D) 1.0

Threat Index- Provided forms (Tip40)

RELIABILITY: Not reported.

VALIDITY: Not reported.

BACKGROUND: This tool was developed to enable the content analysis of death related constructs as apposed to tools that measure the structure of elements within the construct.

PURPOSE: Standardized form of the Threat Index. Provides 40 bipolar dimensions on which the respondent rates "self", "ideal self" and "own death" thinking about the latter as if it were personally imminent.

WHERE TO FIND THE ARTICLE: Neimeyer, R., Epting, F. and Rigdon, M. (1984). A procedural manual for the Threat Index. In, F. Epting and R. Neimeyer (eds.), Personal Meanings of Death, 321-327. WA: Hemisphere Publishing Company.

DESCRITPTION: 30 or 40 questions that investigate 3 elements: self, preferred self and death. A 7-point scale is used to score responses. Scores on either actualization or integration can range from 0 to 40.

DEATH (V/A/D) 1.0

Templer Death Anxiety Scale (DAS)

RELIABILITY: Test-retest reliability = .83 internal consistency coefficient =.76.

VALIDITY: Supported by studies of psychiatric patients and college students. High correlation coefficient (.74) between the DAS and a similar tool (FODS).

BACKGROUND: The DAS was developed to reflect a wider range of life experiences than in other tools that measure death fear/ anxiety.

PURPOSE: Elicits emotional reactions to death and dying.

WHERE TO FIND THE ARTICLE: Robinson, P. and Wood, K. (1984). Fear of death and physical illness: a personal construct approach. In, F. Epting and R. Neimeyer (eds.), Personal Meanings of Death, 213-228. WA: Hemisphere Publishing Company.

DESCRITPTION: 15 questions true/false questionnaire.

DEATH (V/A/D) 1.0

Collet-Lester Fear of Death Scale (FDS)

RELIABILITY: Not reported.

VALIDITY: Supported by low correlation's between four subscales.

BACKGROUND: Developed to distinguish between the fear of death & the fear of the process of dying and to differentiate these fears for one self and for another person.

PURPOSE: Assesses overall fear of death and dying as well as four separate fears: fear of death of self; fear of death of other; fear of dying of self; fear of dying of other.

WHERE TO FIND THE ARTICLE: Collett, L., & Lester, D. (1969). The fear of death and the fear of dying. Journal of Psychology, 72, 179-181.

DESCRITPTION: 36 questions answered on a 6 point Likert scale with the higher score indicative of an endorsement of the fear-indicating items.

GENERAL (V/A/G) 2.0

Attitudes Toward Advance Directives

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: The tool is reported in Davidsen, K. W., Hackler, C., Caradine, D. R. & McCord, M. D. (1998). Physician's attitudes on advance directives, JAMA, 262, 2415-2419.

PURPOSE: Measures physicians' attitudes toward advance directives.

WHERE TO FIND THE ARTICLE: Morrison, R., Morrison, E. and Glickman, D. (1994). Physician reluctance to discuss advance directives. Archives of Internal Medicine, 154, 2311-2318.

DESCRITPTION: Physician's attitudes toward advance directives are assessed by their 14 responses to statements. For physicians who had experienced with advance directives, five additional questions assess the type and extent of their involvement. All responses are assessed on a five-point Lickert Scale.

Values and Attitudes

GENERAL (V/A/G) 2.0

Pankratz Nursing Autonomy & Patient's Right Scale

RELIABILITY: established by two analysis techniques.

VALIDITY: established by two analysis techniques.

BACKGROUND: The present study was an attempt to focus on the views of nurses regarding dependence vs. independence for both nurses and patients. The intent was to identify not only how much freedom nurses see for themselves but also how much freedom they can allow for the patient. The tool was administered to 702 nurses in five different setting (200 RNs in a community teaching hospital; 206 nursing administrators in the Western U.S., & 296 nurses form other hospital settings).

PURPOSE: The purpose of the tool is to examine three separate attitudes in nurses: nursing autonomy, patients' rights and rejection of the traditional role.

WHERE TO FIND THE ARTICLE: Pankratz, L. & Pankratz, D (1974). Nursing autonomy and patient's rights: Development of a nursing attitude scale. Journal of Health Social Behavior, 15, 211-216.

DESCRITPTION: The tool consisted of a 69 item attitudinal scale. A principal components factor analysis resulted in three sub scales that adequately represented the intent of the study: (1) nursing autonomy and advocacy; (2) patients' rights; and (3) rejection of traditional rule limitations. The sub scale scores were associated with education, leadership, academic settings and non-traditional social climate.

Values and Attitudes

GENERAL (V/A/G) 2.0

Blaney/Hobson Nursing Attitude Scale

RELIABILITY: The authors test that the tool is "highly reliable" and exceeds minimum standards.

VALIDITY: Results of tool testing indicate that the tool is valid, according to the authors.

BACKGROUND: The development of the tool is based on the Fishbein & Ajzen model (1972, 1975) which indicates that attitudes are largely based on beliefs about the attitude object. The model emphasizes that there is a critical connection between attitudes and behavior, and that attitudes can be developed and changed by focusing on beliefs about the attitude object.

PURPOSE: Measures nurses' attitudes about cost-effectiveness of nursing practices and procedures.

WHERE TO FIND THE ARTICLE: Blaney, D. R., Hobson, C. J. & Stepniewski, A. B. (1990). Measuring nursing attitudes toward cost-effectiveness: Further development & evaluation of the Blaney/Hobson Scale. In Waltz, C., & Strickland, O. L. (Eds.) Measurement of Nursing Outcome Vol. 3. New York: Springer.

DESCRITPTION: Twenty-two item questionnaire posing cost-related statements that elicit attitudes. Responses are scored on a 5 point Likert Scale ranging from strongly disagree to strongly agree.

Values and Attitudes

GENERAL (V/A/G) 2.0

Survey of Ethical Attitudes

RELIABILITY: Interrater reliability was .92. Correlation reflecting the consistency of subjects' responses across items was .64.

VALIDITY: Indicators of validity are reported.

BACKGROUND: A briefer and more readily scorable test than Kohlberg's MJI. Can be used in parallel with Kohlberg's MJI.

PURPOSE: To measure moral values expressed in moral judgments.

WHERE TO FIND THE ARTICLE: Hogan, R. & Dickstein, E. (1972). A measure of moral values. Journal of Consulting & Clinical Psychology, 39, (2), 210-214.

DESCRITPTION: A 15-item projective measure. Items are in the form of short statements concerning contemporary social & moral issues to which the subject responds as if he were in a conversation. The responses are rated by 5 scores. Each response can receive a score of 0-2.

Values and Attitudes

GENERAL (V/A/G) 2.0

Values History

RELIABILITY: Principal component factor analysis of the 18 value statements discussed three psychologically meaningful factors (communication, family burden, physician compliance). Alphas were .69, .66, .67, respectively. Principal Components analysis of the 11 terminal care directive statements revealed three factors (basic-ongoing care, fundamental- acute, code-support). Alphas were .80, .76, .87, respectively.

VALIDITY: Not Reported.

BACKGROUND: The Values History Instrument was developed because decision making has raised the question of the importance of values in eliciting advanced directives. It supplements the living will and durable power of attorney in the documentation of Advance Directives.

PURPOSE: Identifies values related to advance directives preferences.

WHERE TO FIND THE ARTICLE: Doukas, D, & Gorenflo, D. (1993). Analyzing the values history: An evaluation of patients medical values and advance directives. Journal of Clinical Ethics, 4(1), 41-45.

DESCRITPTION: Two-part instrument using Likert scales and certain demographic data: Part I - surveys values and beliefs in relation to terminal care including 18 value stem questions rated on a 7 point scale from favorable to unfavorable; Part II - assesses familiarity with advance directives on a 5 point scale; Part III - rates 2 quality versus length of life questions on a 5 point scale from strongly agree to strongly disagree; Part IV a scenario of terminal illness is rated on a 5 point scale.

Values and Attitudes

GENERAL (V/A/G) 2.0

Allport-Vernon-Lindzey Study of Values

RELIABILITY: Reported in Manual (1970).

VALIDITY: Reported in Manual (1970).

BACKGROUND: Based on the work for Spranger (1928/1966) who described six values or evaluative attitudes. According to his theory, a person's interest and motives can be understood best by determining the relative prominence of these six basic values. The six basic attitudes are: theoretical, economics, aesthetic, social, political & religious.

PURPOSE: Measures the relative importance of six basic interests or motives in personality.

WHERE TO FIND THE ARTICLE: Allport, G. W., Vernon, P., & Lindsey, G. (1970). Manual for The Study of Values (3rd. ed.) Boston, Houghton Mifflin.

DESCRITPTION: Two part tool: Part I - 30 questions or situations with 3 points between two alternatives for each question; Part II - 4 choices ranked to each of 15 questions in order of personal preference. The numerical values for each item are totaled for a score on each of the six scales.

Values and Attitudes

GENERAL (V/A/G) 2.0

Attitudes Toward Resource Use

RELIABILITY: Scale reliabilities ranged form 0.66 to 0.86) Cronbach's alpha.

VALIDITY: Exploratory factors analysis revealed four factors (fear of malpractice, cost-consciousness, annoyance with utilization review & discomfort for uncertainty). Congruency coefficients for the four factors across 2 data sets ranged from 0.92 to 0.96.

BACKGROUND: Statements related to attitudes that may influence resource use were culled from literature and informal discussions with physicians.

PURPOSE: Measures attitudes that influence resource utilization, especially cost consciousness, discomfort with uncertainty, fear of malpractice, and annoyance with utilization review.

WHERE TO FIND THE ARTICLE: Goold, S., Hofer, T., Zimmerman, M., and Hayward, R. (1994). Measuring physician attitudes toward cost, uncertainty, malpractice and utilization review. Journal of General Internal Medicine, 9, 544-548.

DESCRITPTION: The instrument includes 56 attitude statements in: costs of medical care; uncertainty in decision making; malpractice and liability; medical technology; practice style; and, utilization review. A five point Likert scale was used ranging from (1) strongly agree to (5) strongly disagrees. Questions about demographic & practice characteristics, as well as four items requesting self appraisal of resource use relative to peers, are also included.

GENERAL (V/A/G) 2.0

Values Conflict Resolution Assessment (VCRA)

RELIABILITY: Test/retest reliability was .92 for total score; .84 for Ethical-Emotional subscore, and .88 for Rational-Behavioral Subscore.

VALIDITY: Factor analysis yielded two factors: Ethical-Emotional (eigenvalue =^6.9) and Rational - Behavioral (eigenvalue = 1.86) accounting for 31% of variance.

BACKGROUND: The development of this instrument was influenced by the rejection of The Values Clarification movement during the 1970s. Based on the work of Raths et al. (1966, 1978) it attempts to measure The state of being clarified in terms of one's values assuming that clarifying one's values is a worthy good.

PURPOSE: Assesses the extent to which an individual has resolved specific values conflicts, one at a time.

WHERE TO FIND THE ARTICLE: Kinnier, R. (1995). A reconceptualization of value clarification: Values conflict resolution. Journal of Counseling and Development, 74, 18-24.

DESCRITPTION: The VCRA consists of three parts: conflict description; forced conflict resolution; and, resolution evaluation. Part 1: identification of the specific value conflict Part 2: instruction to attempt to resolve the particular conflict Part 3: evaluation of the resolution by responding to 17 standardized Likert scaled items. The VCRA yields two subscores and a total score of conflict resolution.

Values and Attitudes

GENERAL (V/A/G) 2.0

Values Scale

RELIABILITY: Reported to be good for survey purposes.

VALIDITY: Construct validity is evidenced by the intercollations of The Scales and by their factor structure, construct and concurrent validity are confirmed by sex, age, and curricular data.

BACKGROUND: Not known.

PURPOSE: Provides measurement of a number of intrinsic and extrinsic values not assessed by existing measures. Can be used with upper elementary on middle school students as well as with adults members of various work related or professional groups.

WHERE TO FIND THE ARTICLE: Nevill, D. and Super, D. (1986). The value scale: Theory, application and research manual. Consulting Psychologists Press.

DESCRITPTION: The Values Scale contains 106-items scored for 21 values. The values measured are Ability Utilization, Achievement, Advancement, Aesthetics, Altruism, Authority, Autonomy, Creativity, Economic Rewards, Life Style, Personal Development, Physical Activity, Prestige, Risk, Social Interactions, Social Relations, Variety, Working Conditions, Cultural, Identity, Physical Prowess, and Economic Security.

GENERAL (V/A/G) 2.0

Attitudes Toward Care at the End - of- Life (ATCEL)

RELIABILITY: Was assessed for each construct as well as for each of the 12 items. Intraclass "r" coefficients for the constructs were professional responsibility = 0.75; efficacy of hospice = 0.85, and clinician /patient communication = 0.79. All 12 items together was 0.86.

VALIDITY: Construct validity was assessed by factor analysis. Percent of total variance explained by 3 factors was 47.6%. Factor 1=40.9%; Factor 2=32.3%; Factor 3=26.8%.

BACKGROUND: Improvement of end of life care of patients is needed but this will require attitude changes among clinicians towards terminal illness. Programs to modify clinicians' attitudes are underway but there are not adequate measures of their efficacy.

PURPOSE: To measure physicians' and nurses' attitudes towards care at the end - of - life.

WHERE TO FIND THE ARTICLE: Bradley, E. H., Cicchetti, D. V., Fried, T. R.; et al (2000). Attitudes about care at the end - of- life among clinicians: A Quick, reliable, and valid assessment instrument. Journal of Palliative Care, 16(1): 6-14.

DESCRITPTION: The instrument consists of 12 items that measure three attitudinal contracts: (1) extent of responsibility for care of dying patients, (2) The efficacy of hospice, and (3) the importance of clinicians-patient communication about dying. Uses a 5-point Lickert scale.

MOODS (V/A/M) 4.0

Profile of Mood States Inventory (POMS)

RELIABILITY: High reliability including good internal consistency.

VALIDITY: Content validity was confirmed by factor analysis of eight mood factors.

BACKGROUND: Adjectives are used to describe feelings and moods. Individual scores for tension, anger and depression are used by Olson in the study.

PURPOSE: Measure of patient distress.

WHERE TO FIND THE ARTICLE: Olson, J. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy and patient distress. IMAGE, 27 (4), 317-322.

DESCRITPTION: 65 questions scored on a 5-point scale.

MOODS (V/A/M) 3.0

Multiple Affect Adjective Check List (MAACL)

RELIABILITY: Well supported by Lake, Miles, Earle, 1973; Lubin and Zuckerman, 1967; Zuckerman and Biase, 1962; Zuckerman and Lubin, 1965; Zuckerman, Lubin, Vogel and Valerius, 1964.

VALIDITY: Well supported by Lake, Miles, Earle, 1973; Lubin and Zuckerman, 1967; Zuckerman and Biase, 1962; Zuckerman and Lubin, 1965; Zuckerman, Lubin, Vogel and Valerius, 1964.

BACKGROUND: Not known.

PURPOSE: Measures states of anxiety, depression and anger.

WHERE TO FIND THE ARTICLE: Olson, J. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy and patient distress. IMAGE, 27 (4), 317-322.

DESCRITPTION: Self-administered tool consisting of 132 adjectives from measuring states of anxiety, depression and anger Range of scores: Anxiety: 0-21 Depression: 0-40 Anger: 0-28.

MOODS (V/A/M) 3.0

Behavior Morale Scale

RELIABILITY: A reliability coefficient of 0.95 was obtained using CronbachÕs alpha. Elimination of troublesome items 1 and 13 raised the alpha to 0.98.

VALIDITY: Face validity was determined by a panel of experts. Rank order correlation coefficients from a Denver study indicated significant correlation between the BMS and the morale question by patients (0.60), dialysis partner (0.70) and staff (0.48) indicating that the BMS measured which patient's partners and staff all viewed as "morale."

BACKGROUND: The BMS was developed from the behavioral cues derived from lengthy discussion with dialysis center staff members, who reported that they were making intuitive judgments of patient morale.

PURPOSE: Measures patient morale.

WHERE TO FIND THE ARTICLE: MacElveen, P. (1978). An observational measure of patient morale: The Behavior Morale Scale. Common Nursing Research Bicentennial Year, 9, 85-92.

DESCRITPTION: The BMS is a simple test, quick and easy to administer. The rater observes verbal and nonverbal behavior of the patient for a brief period of time and then rates him on each of 17 items in a 5-point scale relating to posture, body attitude, motor movements, facial expression, speech and verbalizations, and general attitude.

MOODS (V/A/M) 3.0

Profile of Mood States Inventory - Short Version (PMOS)

RELIABILITY: high correlation: r= 0.95.

VALIDITY: Not provided.

BACKGROUND: In an effort to facilitate the use of the POMS with patients under stress or pain, a shorter version of the POMS was developed. Each of the original POMS scales was reduced by 2 to 7 items without losing internal consistency.

PURPOSE: Measures transient, distinct mood states.

WHERE TO FIND THE ARTICLE: Shacham, S. (1983). A shortened version of the profile of mood states. Journal of Personality Assessment, 47 (3), 305-306.

DESCRITPTION: The shortened version consists of 37 items rated on a 5-point scale from 1 = not at all to 5 = extremely.

Values and Attitudes

MOODS (V/A/M) 3.0

Life Regard Index (LRI)

RELIABILITY: high Test-retest reliability reported (r=.80 for Index, r=.73 for sub scale Framework, r=.79 for Fulfillment sub scale.

VALIDITY: Concurrent validity supported in several studies-content validity established by LRI scores significantly related to the degree of subjectsÕ commitment to their personal meanings in life, Thus supporting Theory from which LRI derived, Strong evidence for discrimenant construct validity and predictive validity is reported.

BACKGROUND: The tool was designed by Battista & Almond (1973) to overcome the weaknesses of The Purpose in Life test (PIL) (Crumbaugh & Moholick, 1964). The weaknesses of The PIL include: (a) blending of concepts such as personal meaning, fear of death, and freedom, (b) a lack of consistency in The meanings of PIL items across subcultual groups; and (c) substantial loading on social desirability with Crowne-Marlowe Social Desirability Scale.

PURPOSE: MeasureÕs personal meaning or positive life regurd.

WHERE TO FIND THE ARTICLE: Debats, D.L. (1998). Measurements of personal meaning: The psychometric properties of the life regard index. In P.T.P. Wong & P. S. Fry (Eds.), The Human Quest for Meaning: A Handbook of Psychological Research and Clinical Application, (pp. 237-259). Lawrence Erlbaum Associates, Pales., Mahwah, N.J.

DESCRITPTION: This 28 item questionnaire contains two subscales: Framework and Fulfillment (14 items each), These items are rated on 3 point Likert scales with half of the questions in each subscale worded positively and half worded negatively.

MOODS (V/A/M) 3.0

Abbreviated Loneliness Scale, Version 2 (ABLS - 2)

RELIABILITY: Test-retest reliability of the ABLS-2 is r =. 85 (p < 0.001) with 121 students and one week between testing. Internal consistency, coefficient alpha, was 0.68.

VALIDITY: Supported by the nearly parallel correlations between both the ABLS and UCLA measures of loneliness and a variety of criterion variables. (Self-esteem, social skills, developmental background variables, emotional experiences when lonely.

BACKGROUND: Developed to discover the emotional and behavioral correlates of loneliness as it relates to quality of life and spiritual well being. Authors initially used the UCLA Loneliness Scale, but three problems became apparent: all items were worded negatively and in the same direction (response set bias could influence the scale); responding to a long list of negative items could be a negative experience; and, scale length.

PURPOSE: Measures loneliness.

WHERE TO FIND THE ARTICLE: Paloutzin, R. and Ellison, C. (1982) Loneliness, spiritual well being and quality of life. In L. People and D. Perlman (Eds). Loneliness: A Sourcebook of Current Theory, Research, and Therapy, 224-237. Wiley Interscience: NY.

DESCRITPTION: The tool consists of seven items scored on a 4 point scale: O = often, S = sometimes, R = rarely, N = never. Four of the seven items are stated in the positive direction.

Values and Attitudes

PROFESSIONAL ROLE (V/A/P) 4.0

Nursing Professional Value Scale

RELIABILITY: Reported to be good.

VALIDITY: The validity was established by a panel of five judges who are experts on the code for nurses.

BACKGROUND: This tool was develeoped becuase values are in integral part of nursing, yet no tool existed to accurately measure them. It is based on a review of literature about the nursing code of ethics, values and professional valuein development in nurses.

PURPOSE: Measures professional nursing values based on the American Nurses' Association (ANA) code.

WHERE TO FIND THE ARTICLE: Weis, D. & Schank, M. (2000). An instrument to measure professional nursing values. *Journal of Nursing Scholarship*, 32(2), 201-204.

DESCRITPTION: A 44-item survey using Likert scale. Each item can receive a score of one to five. Possible scores range from 44 to 220, with the higher score indicating a better understanding of nursing values. The items are statements taken from the ANA code and presented with interpretve commentary.

Values and Attitudes

PROFESSIONAL ROLE (V/A/P) 4.0

Role Responsibilities Questionnaire

RELIABILITY: Not provided.

VALIDITY: Not provided.

BACKGROUND: This tool was created to compare the ethical views of nurses around the world and to discover how the Chinese, American, and Japanese nurses view thiew ethical responsibilities.

PURPOSE: To outline sociocultural factors that influence nurses' views of ethical responsibilities.

WHERE TO FIND THE ARTICLE: Pang, S., Sawada, A., Konishi, D. Yu, P., Chan, M., & Mayumi, N. (2003). A comparative study of Chinese, American and Japanese nurses' perceptions of ethical role responsibilities. *Nursing Ethics* 2003, 10(3),295-311.

DESCRITPTION: A list of 56 statements that were taken from statements made by Chinese, American, and Japanese nurses during interviews. The statements fall into four role-relationship categories: responsibilities in relation to society, patients and their families, professional roles, and hospital practices. All 56 statements are ranked on a scale of zero to ten with zero being of no importance. The data is analzed using multidimensional preference analysis.

Values and Attitudes

PROFFESSIONAL ROLES 4.0

Whistle Blowing

RELIABILITY: Reliability was low but that was expected by the designers of the survey because of the nature of the tool.

VALIDITY: Established via Lynn's content validity index.

BACKGROUND: The ethical responsibilities of a nurse dictate that he or she report misconduct on the part of another healthcare worker, which jeopardizes patient safety. Such events often go unreported because of the personal and professional risks imposed on the whistleblower. This survey was designed to compare the differences between the beliefs of those nurses who do act as whistleblowers and those who chose to ignore such incidents.

PURPOSE: To explore the actions and beliefs of nurses who wrestled with the ethical dilemma of whether or not to be a whistleblower.

WHERE TO FIND THE ARTICLE: Ahern, K. & McDonald, S. (2002). The beliefs of nurses who were involved in a whistleblowing event. *Journal of Advanced Nursing*, 38(3), 303-309.

DESCRITPTION: This survey includes ten statements derived from current codes of nursing ethics, traditional views of the role of a nurse and basic beliefs. The statements are rated on a 5-point Likert scale.

Values and Attitudes

SPIRITUAL (V/A/SP) 5.0

Religious Beliefs Instrument

RELIABILITY: Assessed by review of content experts.

VALIDITY: Not reported.

BACKGROUND: The tool was developed so that clinical situations where medical management of patients might be affected by physician's religious beliefs.

PURPOSE: Measures the type and frequency of religious interactions that occur between devout physicians and their patients.

WHERE TO FIND THE ARTICLE: Olive, K. (1995). Physician religious beliefs and the physician-patient relationship: A study of devout physicians. Southern Medical Journal, 88 (12), 1249-1255.

DESCRITPTION: Tool contains: 4 items of demographics; 18 items of religious beliefs survey; 19 items of attitudes and practices regarding interaction between religious beliefs and medical practice; 17 items on attitudes regarding specific biomedical issues; and a comment section. The responses were rated on a 5 point scale ranging from (1) strongly disagree to (5) strongly agree.

SPIRITUAL (V/A/SP) 5.0

Influence of Spiritual Well Being Scale (SWBS)

RELIABILITY: Test/retest reliability coefficient was 0.93. Coefficient alpha was 0.89.

VALIDITY: Face validity is suggested by as examination of item content.

BACKGROUND: The tool was developed to provide additional measurement of quality of life by providing a reliable & valid measure of religious dimensions that contribute to quality of life.

PURPOSE: Measures both religious and existential well-being.

WHERE TO FIND THE ARTICLE: Ellsion, C. (1983). Spiritual Well being: conceptualization and measurement. Journal of Psychology and Technology, 11 (4), 330-340.

DESCRITPTION: The SWBS consists of 20 items, 10 concentrated on religious well being and 10 on existential well being. The items are scored on a 7 point Likert scale.

SPIRITUAL (V/A/SP) 5.0

Spiritual Well Being Questionnaire

RELIABILITY: No information provided.

VALIDITY: No information provided.

BACKGROUND: This tool was developed by combining instruments that measure various aspects of SWB & adding new items including several gallup Poll items (used with permission).

PURPOSE: Measures spiritual well-being

WHERE TO FIND THE ARTICLE: Moberg, D. (1984). Subjective measures of spiritual well-being. Review of Religious Research, 25 (4), 351-364.

DESCRITPTION: 82-item questionnaire . Scoring varied from true/false to a 4-point scale in the various indexes. Seven Indexes were identified: Christian Faith: self-satisfaction, personal piety, subjective sell being, optimism, religious cynicism, and elitism.

SPIRITUAL(V/A/SP) 5.0

JAREL Spiritual Well - Being Scale

RELIABILITY: Established by test-retest method. Pearson correlation of r=0.88 supports stability of instrument. Internal consistency using Cronbach's Alpha in four research studies ranged from 0.79 to 0.91.

VALIDITY: Criterion-related validity was assessed by correlating scores of this scale with those of The Paloutzian & Ellison Spiritual Well-Being Scale. A correlation of 0.82 (p=. 000) between the two scale is reported.

BACKGROUND: Not known.

PURPOSE: To measure spiritual well-being.

WHERE TO FIND THE ARTICLE: Foley, L., Wagner, J., & Waskel, S.A. (1998). Spirituality in the lives of older women. Journal of Women & Aging, 10(2), 85-91.

DESCRITPTION: Scale of 21 items using a 6 point Likert-type format to rate response from strongly agree to strongly disagree.

ETHICS CONSULTATION (E/EC) 1.0

Bioethics Consultation Questionnaire

RELIABILITY: Not known.

VALIDITY: Not known.

BACKGROUND: To study the perceived effectiveness of bioethics consultation as evaluated by both professional staff and their families. An evaluation questionnaire was forwarded to physicians, nurses and patients or family members who were associated with 20 sequential cases referred for ethics consultation during a 2-year period. Respondents were asked to rate the consult as very helpful, somewhat helpful or not helpful concerning a variety of issues related to the care of pts.

PURPOSE: Measures medical ethics consultation effectiveness.

WHERE TO FIND THE ARTICLE: McClung, J., Kramer, R., DeLuca, M. and Barber, H. (1996). Evaluation of a medical ethics consultation service: opinions of patient and health care providers. The American Journal of Medicine, 100, 456-460.

DESCRITPTION: The evaluation questionnaire consists of three sections. In section 1, professional staff is asked the major reasons for calling consultation. In section two, all respondents are asked to answer 7 questions on a 3-point scale: very helpful, somewhat helpful and not helpful. Section three contains 3 written questions asking the respondents opinions and for other comments.

Ethics

PATIENT OUTCOMES (E/PO) 2.0

Illness Severity Measures

RELIABILITY: Cross-validation performance was identical to or only 0.01 points lower than the performance of models developed using the entire data set.

VALIDITY: Each of the six clinical findings has a strong relationship ($P < 0.001$) with in-hospital death which supports the validity of the findings.

BACKGROUND: To determine whether assessments of illness severity, defined as risk for in-hospital death, varied across four measures. For each patient, the probability of death was rated on each of the measure scales. Patients were ranked according to the probability of death as predicted by each severity measures and rankings were compared across measures.

PURPOSE: Measures illness severity and probability of death.

WHERE TO FIND THE ARTICLE: Iezzoni, L., Ash, A., Shwartz, M., Daley, J., Hughes, J. and Makiernan, Y. (1995). Predicting who dies depend on how severity is measured: implications for evaluating patient outcomes. Annals of Internal Medicine, 123, (10), 763-770.

DESCRITPTION: Measures overall severity based on: Admission medic group scores, physiology score, disease stagings scale, and all patient refined diagnosis related groups (APR-DRG). Patients ranked by predicted probability of death.

PATIENT OUTCOMES (E/PO) 2.0

SERVQUAL

RELIABILITY: CronbachÕs alpha = 0.959.

VALIDITY: Not reported by researchers - construct validity reported in original SERVQUAL instrument.

BACKGROUND: Not known.

PURPOSE: Measures patient's reported degree of satisfaction based on consumer satisfaction with services.

WHERE TO FIND THE ARTICLE: Tomes, A. and Ng, S. (1995). Service quality in hospital care: The development of an inpatient questionnaire. International Journal of Health Care Quality Assurance, 8 (3), 25-33.

DESCRITPTION: 49 statements rated on a 7 point Likert scale ranging from 7 = strongly agree to 1 = strongly disagree.

PATIENT OUTCOMES (E/PO) 2.0

SERVQUAL- Short form

RELIABILITY: The total scale reliability was reported as Ôclose to .9Õ in each of the four instances.

VALIDITY: Construct validity reports based on conceptual criterion and empirical measures.

BACKGROUND: Not known.

PURPOSE: To assess consumer perceptions of service quality in service and retailing organizations.

WHERE TO FIND THE ARTICLE: Parasurman, A., Zeithaml, V. and Berry, L. (1988). SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality. Journal of Retailing, 64 (1), 12-40.

DESCRITPTION: 22-item scale scored on a 7-point scale ranging from 7 = strongly agree to 1 = strongly disagree.

World Views

ETHICAL IDEOLOGIES (WV/EI) 1.0

Ethics Position Questionnaire

RELIABILITY:

CronbachÕs alpha was .80 for idealism and .73 for relativism

Test-retest was .67 for idealism and .66 for relativism.

VALIDITY:

Varimax rotation for 16 items = 77%

Construct and discriminate validity were established.

BACKGROUND: The EPQ assesses the degree of idealism and rejection of universal moral rules in favor of relativism to evaluate to what extent individuals adopt the ethical ideologies under different types of moral judgements.

PURPOSE: Measures the extent to which individuals adopt one of four ethical ideologies: situations, absolutism, subjectivism, and exceptionism in making moral judgements.

WHERE TO FIND THE ARTICLE: Forsyth, D. (1980). A taxonomy of ethical ideologies. Journal of Personality and Social Psychology, 39(1), 175-184.

DESCRITPTION: The questionnaire contains 20 attitude statements, 10 concerning idealism and 10 concerning relativism. Respondents are asked to indicate their degree of agreement or disagreement with each item using a 9 point scale. The scale ranges from 1 = completely disagree to 9 = completely agree.

World Views

RESEARCH (WV/RS) 2.0

WorldViews of Faculty Research Investigators

RELIABILITY: Not reported.

VALIDITY: Not reported.

BACKGROUND: Letter of introduction and questionnaire sent to faculty members in dentistry, nursing or pharmacy holding both a professional and doctoral degree.

PURPOSE: Asseses the world views of faculty investigators for recognition of ethical issues and weighing of ethical principles in human subject research.

WHERE TO FIND THE ARTICLE: Not available.

DESCRITPTION: The questionnaire consists of 59 items scored on a five point scale ranging from 1 = never important to 5 = always important.