# ACADEMIC AND CLINICAL DISHONESTY IN UNDERGRADUATE NURSING STUDENTS

by

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***ACADEMIC AND CLINICAL DISHONESTY IN UNDERGRADUATE NURSING STUDENTS***

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## ABSTRACT

Title: ACADEMIC AND CLINICAL DISHONESTY IN UNDERGRADUATE NURSING STUDENTS.

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The purpose of this study was to describe the incidence of, and reasons for, academic and clinical unethical behaviors among undergraduate nursing students currently enrolled in rurally located schools of nursing. Several factors were used for purposes of comparison, including number of years education, type of nursing education preparation, and exposure to a nursing ethics course. The objective of this specific study was to broaden the available knowledge base in the area of unethical behavior, by providing data on the self-reported behavior of nursing students in rurally-located schools of two different preparation types: Associate's degree and Baccalaureate.

As a profession, nursing has a prescribed Code of Ethics to uphold. In order to maintain and expand upon the respect with which the profession is viewed, nurses must be aware of breaches in ethical behavior by students preparing to enter the profession. Unless nurses are fully aware of the prevalence of such behavior, and the patterns involved, the profession will be unable to design appropriate interventions and preventative practices.

The target population for this study was nursing students enrolled in rurally located undergraduate schools of nursing. The study sample consisted of 177 nursing students, selected from the following schools of nursing; Salisbury State University, Delaware Technical College,

and Wor-Wic Community College. Convenience samples of intact classes were sought, with approval of the institution and instructors involved. Subjects were asked to anonymously complete the questionnaire, Hilbert Unethical Behaviors Survey (HUBS). The tool consisted of twenty-two items, each requiring a numerical entry, corresponding with the number of times the subject participated in a given behavior. In addition, two qualitative questions were included, regarding the reasons for such behaviors.

Permission was obtained from the Human Subjects Committee of Salisbury State University prior to data collection. All data collection was completed by the student researcher, with no one else having access to the completed questionnaires or the raw data, prior to coding. Full disclosure was provided to the subjects, who were then given the instrument, with the explanation that they may choose to participate fully, partially, or not at all. Signed informed consent was not obtained, since participation implied consent. Once data was coded, the questionnaires were destroyed by the student researcher.

The findings of this study supported only one of the hypotheses put forth by the researcher. A positive correlation was found between classroom and clinical behaviors. The other hypotheses which related to quantitative data were not supported. The researcher includes some possible explanations for this finding and some suggestions for further study.

The qualitative data obtained in this study were rich and varied, providing insight into the research question regarding reasons and explanations for unethical behaviors. A new model, "Stages of moral development in the professional nurse," was developed by the researcher, based on the information obtained in this study. The implications of this model and suggestions for model testing are included.

## Dedication

Dedicated to my family, whose patience and faith has sustained me through many months of work:
My husband, Ted and sons Drew, Shaun and Brendan.

Additional acknowledgement is given to my committee, especially to Dr. Ruth Carroll, who assisted, directed, cajoled and cheered me through every step.

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## Chapter I: Introduction

### Code of Ethics for Nurses

The subject of ethics is not a new one in nursing curricula, although the approach has changed. As early as the late nineteenth century, ethics was a part of nursing instruction:

> In the early days, the emphasis of ethics was upon the production of a virtuous and obedient woman, loyal especially to the doctor and to the institution which employed her. The emphasis now is upon the production of an independent and responsible professional whose loyalty is, foremost, to her/his patients.
> (Allmark, 1995, p. 374)

Cassells and Redman agreed with the above description of modern nursing ethics education in their 1989 report:

> The ideal model by which professional nursing students would be prepared to meet these [ethical] challenges has undergone dramatic change in the past 30 years, from a focus on rule ethics to situational ethics, and beginning in 1975, from a focus on professional codes to particular moral dilemmas and the role of the nurse as an ethical agent and patient advocate. (p. 464 )

Since 1985, nurses have been guided in their practice by the guidelines in the American Nurses Association Code for Nurses (ANA, 1985), which uses terms such as advocacy, respect, privacy, truthfulness, accountability, and maintenance of competence to define integrity in nurses. Additionally, the American Association of Colleges of Nursing has provided guidelines for the education of nursing students, in regards to ethics (AACN, 1986). These list seven values to which the professional nurse should be committed; altruism, equality, aesthetics, freedom, human dignity, justice and truth (AACN, 1986). So, there has long been agreement that there are ethics particular to nursing practice, and that educators are responsible for instilling these in their

students. As one pair of nurse educators see it, ethical guidelines make up one of the most important content areas in nursing education:

> One of our greatest concerns as educators of nurses is to instill in future professionals an unshakable sense of their duties and obligations, which arise from the professional code of ethics and are consistently supported by the ANA standards of practice. (Booth & Hoyer, 1992, p. 90)

Yet, there is still little consistency between schools of nursing, regarding the teaching of ethics (Allmark, 1995; Quinn, 1990; Nolan & Smith, 1995). One nurse researcher says concisely, "Despite this level of agreement on the desirability of teaching ethics to nurses there are still uncertainties over what to teach and how to teach it," (Allmark, 1995).

The National League for Nursing (NLN) added their voice to the fray in 1990, with a resolution on nursing education, the major tenets of which reflect caring as a core value in nursing.

> The resolution calls for NLN to encourage development of curricula that reflect these goals:
> - enhancement of caring practices through faculty-student and faculty-to-faculty relationships that are egalitarian and characterized by cooperation and community building;
> - social values that recognize the multi-cultural, multi-racial, and growing diversity of both individual and family lifestyles in our society;
> - learning experiences that incorporate critique of the current health care system and analysis of the present and future health needs of the population as the basis for transforming the health care system; and
> - substantive contact with, or participation by, persons at health risk.
> (Tanner, 1990, p. 70)

Thus, the value of caring was added to the seven values already prescribed above for nurses. At least one nurse educator sees this as problematic, however, as she points to what she sees as nursing's central dilemma, "that nurses have been ordered to care in a society that does not value caring" (Aroskar, 1991).

Other researchers have found that caring, as an ethical value, is not exclusive to nursing, but is more prevalent in females than males (Hoyer et al, 1991; Nolan & Smith, 1995; Peter & Gallop, 1994). Since nursing remains a predominantly female profession, it is not surprising that caring is seen to be an integral value.

## Values Held by Nursing Students

There is little recent research into the ethics and values that nursing students bring with them, but there are a few studies comparing the values of nursing students to those of medical students, using small convenience samples. Although this research is far from conclusive, it is included here as the best information available at this time. A study by Nolan and Smith (1995) showed that students in both career paths bring some knowledge of ethics with them, and that "a large number were religious believers and a significant number practiced their religion." Interestingly, these researchers also found that both nursing and medical students found it far easier to make ethical decisions about animals than about human beings. Another study showed that, although gender differences occurred on the issue of caring, as previously discussed, "both genders, and both nursing and medical students, tended to use a mixture of care and justice considerations," in regards to ethical decision making (Peter & Gallop, 1994).

A few studies have attempted to document actual unethical behavior among nursing students, and to compare the incidence found with that in other academic majors (Hilbert, 1988; Daniel, Adams & Smith, 1994; Bradshaw & Lowenstein, 1990). In general, the incidence of academic dishonesty, defined as lying, cheating and/or plagiarism, was found to be less for nursing students than that reported for other college majors. Because all of these studies used self-report questionnaires, there is always the possibility that nursing students are more likely to lie about their misconduct because of the strong code of ethics in the profession. However,this is the best information available, and it does address an area of potential concern, as one group of

researchers state;

> Concern over possible academic misconduct among nursing students is particularly warranted because of the serious potential risks associated with placing a less than adequately prepared individual in the health care delivery system.
> (Daniel et al., 1994, p. 278)

## Ethics in Nursing Curricula

Because there is no clear consensus on the ethical background to expect in nursing students, and because the dynamics of the student nurse population, like those of society, are in a constant state of flux, nurse educators are forced to make individual assessment of the ethical needs of their students. Perhaps for this reason, there is no universally accepted method of teaching nursing ethics. There are, however some common themes in most nursing ethics curricula. These include academic integrity, professional integrity, the ethics of caring, and patient advocacy (Quinn, 1990; Allmark, 1995). An additional component often included is that of personal values clarification (Kopala, 1994), but that topic will not be included in this discussion because, by definition, it is personal and individual.

As a group of nurse educators describe the purpose of ethics in education;

> The aim of education is intellectual and moral autonomy. The role of the educator is not to transmit knowledge and values to students, but to encourage students to construct values and to make decisions for themselves (Davis et al., 1996).

The goal of the next few sections of this paper will be to look at what is being taught currently in nursing schools, in relation to ethics.

### Academic integrity

A group of nurse educators from the University of Alabama School of Nursing recently published a paper succinctly describing the need for teaching academic integrity, in which they

stated:

> A code of behavior is particularly relevant in today's academic environment... students are older and have more ethnic and gender diversities, more life and work experience, and greater work and family responsibilities. As a result of these diversities, they may evidence different values. However, expectations are the same for all students (Davis, Johnston, DiMicco, Findlay & Taylor, 1996, p. 24).

Although research shows that the majority of nursing students have probably been exposed to the value of academic integrity, it is unclear how this socialization to the professional academic values of nursing is being continued. It is often unclear what example is being taught to potential nursing students by society at large, as Booth and Hoyer point out;

> In the 1990's, the media have continued to publicize examples almost daily of well-known citizens who appear to have compromised themselves by allegedly becoming involved in illegal or unethical practices or partnerships. In contrast, societal, family and professional role models who are ethical and honest and who demonstrate high integrity seldom receive attention. Exemplary actions are found in some remote section of the newspaper or are alluded to briefly by a newscaster who is trying to accommodate an unexpected excess of air time (Booth & Hoyer, 1992, p. 87 ).

The main forms of education in regard to academic integrity appear to be faculty role modeling, and listing of consequences for dishonesty (Bradshaw & Lowenstein, 1990; Hoyer et al, 1991, Kopala, 1994; Quinn, 1990; Allmark, 1995). It is unclear which of these is more effective, or indeed if either is effective.

**Professional integrity**

Although the profession of nursing has clearly shown, in the codes discussed above, that there is a desire to promote professional integrity, there is still debate over what that means in terms of education, and what is the purpose of such education. Allmark explains this clearly, "it is unclear whether we are teaching ethics because nurses are professional or in order that they may become professional. That the latter is sometimes the case may be seen in the emphasis in some of

the literature on the need for ethics to 'empower' the nurse," (Allmark, 1995, p. 374).

In regards to how the morals and ideals of the profession are being passed on to students, there appears to be little course content. Ethics as a curriculum is usually taught in client-centered case study manner (Quinn, 1990; Thompson, 1991; Macrina & Munro, 1995). This deals with only a portion of professional integrity, that of the professional nurse's relationship with her/his client, but ignores the portion that defines the group's relationship with society as a whole. "The transmission of professional values and ideals is typically considered professional socialization, a content and process area separate and distinct from nursing ethics," (Quinn, 1990, p. 727).

In addition, although faculty clearly serve as role models of the profession, it has been shown that the values they model are sometimes in conflict with those of the profession as a whole;

> The value hierarchies of nursing practice and nursing education are not identical. . . In particular, student nurses observe their instructors applying a hierarchy of values that often places student learning above what may be in the patient's best interests (Kopala, 1994, p. 236).

Because the reasoning behind this is rarely explained to students, they may experience confusion as to their expected role in the profession.

## Statement of the problem

### Purpose of the study

The purpose of this study was to describe the incidence of academic and clinical unethical behaviors among undergraduate nursing students currently enrolled in rurally located schools of nursing. Several factors were used for purposes of comparison, including number of years education, type of nursing education preparation, and exposure to a nursing ethics course.

### Significance

As a profession, Nursing has a prescribed Code of Ethics to uphold. In order to maintain and expand upon the respect with which the profession is viewed, we must be aware of breaches

in ethical behavior by students preparing to enter the profession. Unless we are fully aware of the prevalence of such behavior, and the patterns involved, we will be unable to design appropriate interventions and preventative practices.

## Chapter II: Review of Literature and Conceptual Framework

### Review of Literature

### Academic fraud in college students, across majors

#### Studies of incidence

The problem of unethical among college students has been a subject of study for many years (Campbell, 1933; Fass, 1936), with the earliest studies concentrating on students cheating on tests in the "traditional" classroom setting. Estimates of the prevalence of college cheating, based on these findings and similar studies that followed, predicted that more than half of the population had, or would, cheat at some time during their college career (Campbell, 1933; Fass, 1936; Bowers, 1964; Canning, 1956; Haines, Diekhoff, LaBeff & Clark, 1986). The Bower's (1964) study was a large and expensive project, involving a randomly selected student sample (n=5280) from 99 different institutions. Fully half (50%) of the subjects in this study admitted to academic cheating, related to test taking. The size of the sample chosen for this study contributed to widespread acceptance of these findings.

Interest in studies of the incidence of academic fraud declined during the 1950's, 1960's and 1970's. The few studies which were completed and published during this time tended to accept that the incidence of cheating had already been established, and include that as one of the assumptions (Canning, 1956; Bushway & Nash, 1977). The one informal study relating to incidence, actually more of a poll, completed during this time frame at Michigan and Dartmouth, showed that greater than 60 percent of undergraduates surveyed had violated the school's honor code at least once (Lamont, 1979). This was also the first study to include behaviors related to course work in settings other than traditional classrooms, such as drylabbing of science laboratory experimental results.

Haines, Diekhoff, LaBeff and Clark (1986) reported a cheating incidence of 54%, and found a wide variety of variables which partially predicted these behaviors. This study was replicated in 1996 by Diekhoff et al., with similarly serious results; the incidence rate of self-

reported cheating in the later study was 61% (Diekhoff et al., 1996), using the same instruments, at the same institution.

Some studies have shown even higher incidence rates, such as Baird's (1980) study of 200 college students, which showed an incidence of 75.5% for cheating behaviors, although the study looked only at plagiarism and test cheating. In a study by Sierles, Hendrickx and Circle (1980), which attempted to compare unethical behavior in college students in general with that of medical students, an incidence rate of 87.6% was obtained for the college student sample. In comparison, 58.2% of medical students sampled admitting to cheating in the same study. Although this finding has been criticized as being inflated (Rozance, 1991), at least one study has come very close to producing similar results. In a study of 623 undergraduate students at a large state university, Michaels and Miethe (1989) found a total self-report rate of 85.7% for all cheating behaviors studied.

Almost without exception, studies of academic fraud and cheating behaviors have relied on self-report questionnaires, conducted using various "anonymous" methods. More recent studies, using alternate methods, such as the randomized response technique, have shown rates of incidence much higher than previous studies, raising the possibility that the data collected over the past 60 years in this area may have included large underreporting errors (Scheers & Dayton, 1987; Ferrell, 1992b). The Scheers and Dayton study (1987) looked at specific unethical behaviors, such as copying answers on an exam, and found that underreporting ranged from 39% to 83%, with the highest rate of underreporting occurring in relation to the item "purchased a term paper". Because of these findings, interest in studying the incidence of academic fraud is again beginning to increase.

In an attempt to combat the risk of underreporting inherent to self-report measures, Gardner, Roper, Gonzalez and Simpson (1988), arranged to observe 245 college students. The subjects were observed while completing out of class study guide assignments over the course of an entire semester. By the end of the study, more than 98% of the subjects had cheated at least

once (Gardner et al., 1988). In another study involving observation, Karlins, Michaels and Podlogar (1988) found an incidence of only 3%. The researchers theorized that the low rate may have been related to the fact that the observation involved completion of an ungraded assignment (Karlins et al., 1988.)

In addition to the risk of underreporting, there are several other cautions that must be applied in comparing the rates of incidence found in these studies. First, there is the fact that each study has used a different tool, with varying areas of study related to academic fraud. Although there is a certain amount of overlap of items, there are areas that are unique to several of the studies. The twelve items found most commonly among the studies of the eighties and nineties are listed below,quoted from a Genereux and McLeod study:

> -Tell exam questions to a student who has yet to write the exam.
> -Get exam questions from a student who already wrote the exam.
> -List false references on a paper.
> -Allow a student to copy your answers in an exam.
> -Plagiarize on a term paper.
> -Make up research data.
> -Copy exam answers from someone.
> -Use an unauthorized cheat sheet.
> -Allow another student to hand in one of your assignments/papers.
> -Give yourself extra marks when self-marking a test.
> -Hand in a friend's paper or assignment as your own.
> -Hand in a paper or report you bought as your own (1995, p. 697).

Fass (1990) included unethical use of academic resources, tampering with the work of others, questionable practices regarding computer usage and failing to adhere to academic regulations in a study of academic fraud. The more types and/or headings that are included in a study, the higher the incidence rate reported. Many of the studies actually focused more on the reasons for the fraud than on the incidence or types of fraud, as is the

case with the Genereux & McLeod (1995) study.

The most comprehensive list of unethical behaviors for college students is found in Maramark & Maline (1993), and includes such detailed entries as:

-Copied materials without footnoting.
-Feigned illness to avoid a test.
-Submitted same term paper to another class without permission.
-Reviewed previous copies of an instructor's test.
-Reviewed a stolen copy of an exam.
-Turned in a dry lab report without doing the experiment.
-Sabotaged someone else's work (on a disk, in a lab, etc.).
-Collaborated on homework or take-home exams when instructions called for independent work.
-Shared answers during an exam by using a system of signals.
-Developed a relationship with an instructor to get test information.
-Engaged in bribery or blackmail.
-Attempted to bias instructors' grading after an exam.
-Altered or forged an official university document. (p. 4)

Caution is needed in interpretation and comparison of incidence rates in these various studies. Even when the types of fraud being studied were the same, the instruments used were not the same, and there has been little evidence provided of the validity of the tools. Daniel et al's (1991) study is the only one which offers construct validation of their instrument, the Academic Misconduct Scale (AMS). This tool, however, has only been utilized, to date, to study classroom behavior of nursing (Daniel et al., 1994) and education majors (Ferrell & Daniel, 1995; Ferrell, 1992a; Ferrell, 1992b).

Studies of subject traits

The first studies of college cheating attempted to build on the studies done in the 1920's regarding cheating in elementary and high school, which had established a relationship between

low academic standing and the propensity to cheat. The findings of early college studies, which attempted to correlate cheating with grade point average (GPA) and other academic measures, were consistent with one another in showing a positive relationship between test cheating and low academic achievement, based on reported GPA (Campbell, 1933; Fass, 1936), but did not look at other types of fraud, such as plagiarism. A recent study, which included the factor goal GPA, rather than actual GPA, showed that a high goal GPA was a significant predictor of a variety of unethical behaviors, especially in male and firstborn subjects (Genereux & McLeod, 1995).

During the fifties to the seventies, as interest in the incidence of academic fraud seemed to wane, interest in the characteristics of those most likely to cheat was on the increase. Major studies of this time tended to focus on identifying the group(s) most likely to commit academic fraud. Variables studied included gender (Johnson & Gormly, 1972; Hetherington & Feldman, 1964), environmental controls, such as honor codes (Canning, 1956), and personality attributes of the subjects (Sykes & Matza, 1957; Hetherington & Feldman, 1964; Johnson & Gormly, 1972).

Gender findings showed a significantly higher rate of self-report for academic fraud among males (Johnson & Gormly, 1972; Hetherington & Feldman, 1964; Newhouse, 1982; Karlins et al., 1988). In a study of 137 education students, Wilkinson (1974) found no apparent difference in rates, based on gender or age of students. There were, however, an unequally small number of male subjects in this study. Similarly, in a study of 428 medical school students, Sierles, Hendrickx and Circle (1980) were unable to show a correlation between reported unethical behavior and gender, perhaps due to the low number of female subjects included. Yet,in a recent study of 365 Canadian urban community college students, 49% male, 51% female, males were again found to be significantly higher in self-report of unethical behavior (Genereux & McLeod, 1995). Jendrek (1992) found males more likely to cheat, and also more likely to ignore observed cheating.

Environmental controls, such as honor codes, have been the subject of several studies, with mixed results. Canning (1956) found some reduction of unethical behavior in schools with

honor codes in place, but this may only be due to a reduced rate of reporting. In a study of medical students, in a school with an honor code in place, Simpson, Yindra, Towne and Rosenfeld (1989), found that 15 students had anonymously reported cheating, yet only 2 had gone on to make formal reports. Gardner et al. (1988) found no difference in observed cheating between schools with an honor code in place and those without. In a 1993 study of undergraduate psychology majors, using self-report, May and Loyd found evidence to suggest that incidence of unethical behavior is less in schools with an honor code. The subjects chosen in the honor code school were given extra course credit for participation and knew the hypothesis to be tested in advance (May & Loyd, 1993), making these results somewhat suspect. Jendrek (1992) reported that honor codes are unlikely to be successful, since faculty members often do not understand or utilize them.

Genereux and McLeod (1995) looked at the factors, identified by the student subjects, which were likely to increase the likelihood of cheating. They found that, "Pressure on the student to obtain good grades and an instructor who does not seem to care about cheating are apparently particularly important triggers for cheating, yet lack of pressure and an instructor who clearly disapproves of cheating are not particularly strong deterrents of cheating", (Genereux & McLeod, 1995, p. 699). Newhouse (1982) found that students who reported themselves as feeling alienated from their instructors and the academic environment were also more likely to report cheating.

Another predictive factor found in several studies is that of level of education. Baird (1980) found that unethical behavior tended to decrease as educational level increased, although this was not found directly related to age. In a similar finding, Harp & Taietz (1966) found those students who expressed an interest in attending graduate school were less likely to cheat than those who expressed no such interest. Haines et al. (1986) found that younger, single students with increased outside activity involvement were more likely to cheat, especially those students who were not paying directly for their own education. Diekhoff et al. (1996) found that students less personally invested in their education and those on scholarships, with poor grades, were more likely to report themselves as cheaters. Competitive nature (Perry, Kane, Bernesser, & Spicker,

1990) and low work ethic (Eisenberger & Shank, 1985) of the subjects have also been studied and show significance as predictors of cheating behavior.

Several theories were expounded during this time which attempted to explain cheating in relation to the subjects' level of moral reasoning (Kohlberg, 1969), ability to neutralize feelings of guilt (Sykes & Matza, 1957), and social position (Harp & Taietz, 1966). These theories continue to provide the framework for many of the studies to date.

When using Kohlberg's moral reasoning theory, the hypothesis is that a higher level of moral reasoning will produce a reduction in the incidence of unethical behaviors (Kohlberg, 1969). This theory has been tested by many, with mixed results overall (Jeffreys & Stier, 1995; Nokes, 1996; Rest, 1975; Cassidy, 1996). This may be because of varying definitions of academic fraud, as is proposed by several researchers (Stern & Havlicek,1986; Singhal, 1982; Barnett & Dalton, 1981), or because, as one author puts it, "Although many students admit that cheating is morally wrong, they rarely report another student's cheating...[and may] view cheating as a legitimate means for getting ahead and coping with stress," (Maramark & Maline, 1993, p. 5).

A criticism of Kohlberg's theory is that all the original studies, on which the theory is based, were conducted using male subjects only, so that the tenets may not be generalizable to females (Gilligan, 1982). Several researchers, however, have found no significant difference between males and females, using the Kohlberg interview and the associated tool (Rest, 1975; Walker, 1984; Nokes, 1989; Duckett et al., 1992).

This legitimizing, or neutralizing, of cheating and related feeling of guilt is central to the theories postulated by Sykes & Matza (1957) and refined by Haines et al. (1986). In both of these studies a significant relationship was found between incidence of self-reported cheating behavior and the level of neutralization reported by the individual (Sykes & Matza, 1957; Haines et al, 1986). These results were replicated by Lipson and McGavern (1993) in a study conducted at the Massachusetts Institute of Technology, which found that many students were able to rationalize away nearly all feelings of guilt associated with academic fraud.

There were no attempts to look at individual courses and/or fields of study until the latter half of the century. The first group of college students to be studied, not surprisingly, were psychology majors (Hetherington & Feldman, 1964), with medical students following after a period of nearly twenty years (Sierles et al, 1981). Nursing soon followed (Carmack, 1984; Hilbert, 1985). The impetus for all these studies came from the Bower's (1964) study, which looked at 5,280 college students from all majors, but also broke down incidence rates by school of study, with the highest rate of academic fraud occurring in schools of business and commerce (66%), engineering (58%), education (52%), and social sciences (52%).

## Academic and clinical dishonesty by nursing students

Because of the high degree of trust given to those in the health fields by the public in general and clients in particular, findings of academic fraud in nursing and medical education programs have drawn a great deal of attention.

The earliest study of academic fraud in nursing students was a qualitative, descriptive study conducted through interviews with nursing faculty from 11 different schools of nursing, from diverse areas in the United States (Carmack, 1984). Areas of exploration included: perceptions regarding prevalence of plagiarism, formal policies on plagiarism, level of administrative support, colleague support, and the relationship between academic and professional dishonesty (Carmack, 1984). Major suggestions for decreasing plagiarism, which came from this study included decreasing the stress level of nursing students and increasing support for students. Carmack also suggests that nursing faculty need to better define what constitutes academic fraud and what punishments are to be given. The author also suggests further research into, "the actual extent, range, attitudes, and feelings about academic dishonesty in schools of nursing" (Carmack, 1984, p. 33).

As the first to conduct quantitative research into the subject of fraud in nursing students,

Hilbert (1985) used a questionnaire which was newly developed at the time. The Hilbert Unethical Behaviors Survey (HUBS) used items based on a literature review regarding academic fraud in general, and additional items added based on a survey of 16 nursing faculty members. Results of this first study showed a much higher incidence of unethical behaviors than had been expected, but were lower than the Pemberton (1983) study of undergraduates, non-nursing majors, which Hilbert used as a comparison.

Hilbert conducted several studies in this arena, using the same tool on different groups of undergraduate baccalaureate nursing students (1985; 1987; 1988). The HUBS tool was the first instrument designed to look at fraud and unethical behaviors in the clinical setting. In the Hilbert studies, students actually admitted to such unethical behaviors as stealing hospital equipment, documenting medications or treatments not actually performed, and taking patient medications for personal use (1985; 1987; 1988). The findings were surprising enough to gain national attention, which led to many more studies of academic and clinical cheating by nursing students (Bradshaw & Lowenstein, 1990).

The most common reason given in the 1987 Hilbert study for engaging in unethical classroom behaviors was pressure for good grades, yet the most common reason given for unethical clinical behaviors was that the behavior did not seem unethical, especially in relation to discussion of patients in public places or with non-medical personnel (Hilbert, 1987). Many respondents (18%) cited "I thought I wouldn't get caught", as a reason to cheat in the classroom, and 14% cited this reason for clinical unethical behavior, as well (Hilbert, 1987, p. 43). GPA and age were not found to be significant predictors of unethical behaviors (Hilbert, 1987), but this result may be biased by the fact that there was little variability to the subject's ages, and GPA (Hilbert, 1987). There were no significant differences found between nursing and non-nursing students at the same site (Hilbert, 1987), suggesting that, given the same environment, nursing students were no more or less likely to cheat that the college population at large.

In all of the Hilbert studies, a significant correlation was found between unethical

classroom and clinical behaviors (1985; 1987; 1988), which Hilbert postulated could be related to, "A personality characteristic of the individual, such as level of moral development, may be a contributing factor," (Hilbert, 1987, p. 43). However, when Hilbert sought support for this hypothesis, the findings showed, in the words of the researcher, "The theory that the level of moral judgement is inversely related to unethical behaviors was supported for the clinical area, but not for the classroom," (Hilbert, 1988, p. 167). Kohlberg's Defining Issues Test (DIT) was used as a second tool for the study (Hilbert, 1988), with mixed results, suggesting that there may be other factors involved that could assist in prediction of unethical behaviors.

Using a semi-structured interview in a qualitative exploratory study, Bailey looked at cheating among nursing students from the instructor's perspective, using a systematically chosen sample of 400 nursing faculty members from 200 different institutions, with a response rate of 44% (Bailey, 1990). Although 60% of the respondents reported having experienced at least one cheating incident with their students, the rates of incidence reported for clinical behaviors were much lower than the Hilbert studies would lead one to expect, with less than one percent reported for each of the clinical behaviors studied, which were taken from the HUBS tool (Bailey, 1990). Apparently, there is reason for students' belief that they wouldn't get caught. The relatively low rate of discovery for incidents of both classroom and clinical cheating, as reported by students, was addressed by Bradshaw and Lowenstein (1990). These researchers suggested that many students "May find themselves in a pattern of behavior from which they wish to be extricated," and that they may, subconsciously at least, want to get caught (Bradshaw & Lowenstein, 1990, p. 13).

Clinical unethical behavior and its relationship to moral development was the subject of a paper by Hoyer, Booth and Richardson (1991), which sought to provide a theoretical framework, based on Kohlberg's model of moral development (1969), specific to clinical unethical behavior in nursing students. A similar framework was used for a study comparing the ethical awareness of first year medical, dental and nursing students (Nolan & Smith, 1995). A total of 174 students were included in the study, with the percentage of females ranging from 39.7% in the dental

school, to 100% in the nursing school sample (Nolan & Smith, 1995). There was no statistically significant difference found, in terms of moral development, between groups, which were homogeneous in terms of age (mean age = 18.5 years) and educational experience (Nolan & Smith, 1995).

In contrast, Daniel, Adams and Smith (1994), used Maslow's Needs Model of Human Motivation, or Need-Goal Model, as a basis for the study of academic misconduct among nursing students. This study attempted to explore the motivational factors behind cheating. Haines et al.'s (1968) neutralization scale was also incorporated (Daniel et al., 1994). Using a tool previously developed for studying the propensity for academic misconduct in education majors, the AMS, the Daniel et al. (1994) study attempted to look at students' perceptions of their peers' level of maturity, commitment and neutralizing attitude in comparison with perceptions of peers' level of participation in misconduct. Subjects chosen for this study included both associate and baccalaureate nursing students from five schools of nursing, all located in the southern United States, with 90% of respondents being female. Findings provided further corroboration that "Age, marital status, seriousness, and ability level are not perceived as being related to academic misconduct," (Daniel et al., 1994, p. 286). They did find support for at least one of the hypotheses, however, in that, "As a set, neutralization and maturity/ commitment variables accounted for approximately 33% of the variance in the misconduct subscale scores," (Daniel et al., 1994, p. 285). This suggests that the factors which predict misconduct may be multiple and interdependent. It must also be considered that 67% of misconduct remained unexplained through any of the factors studied (Daniel et al., 1994).

Summary of findings

Overall, studies have shown that nursing students do cheat (Bailey, 1990; Carmack, 1984; Daniel et al., 1984; Dierckx de Casterle' et al., 1996; Harnest, 1986; Hilbert, 1985; 1987; 1988). What remains unclear is whether nursing students are truly less likely to cheat than other college

students, as some researchers have suggested (Hilbert, 1987), or simply less likely to admit to unethical behavior.

One researcher has found a positive correlation between unethical behaviors in the classroom and in the clinical setting (Hilbert, 1985; 1987; 1988). There are no studies to date attempting to correlate unethical behavior as a student with clinical unethical behavior of graduate nurses, yet this is assumed to be probable (Davis et al., 1996; Allmark, 1995).

Several theories, taken from other disciplines, have been offered to explain and predict unethical behaviors in nursing students (Hoyer et al., 1991; Daniel et al., 1994; Bradshaw & Lowenstein, 1990). These theories have proven useful in predicting some types of unethical behavior, but have not been able to predict factors that discourage unethical behavior among nursing students. No theory or framework has been developed by and for nursing as yet.

Areas needing further research

To date there are no studies comparing associate degree and baccalaureate nursing school programs, to see which type tends to facilitate unethical behavior, or attract students with a higher propensity for cheating. Because only one study included associate degree nursing students (Daniel et al., 1994), it is difficult to know the degree to which previous findings are generalizable to these groups.

There also has been no attempt to look at potential differences among nursing students from small, rural schools. Just as rural residents tend to be different from urban ones, students in rurally located nursing schools may be different in their propensity for unethical behavior from those in large urban nursing schools.

The tools which have been used to date also need further refining. Although the HUBS has been widely accepted, there have been no studies done regarding the reliability or validity of this tool. Also, as Hilbert points out, some of the items, such as discussion of patient information with non-medical personnel, may have to be removed or reworded, because of the high number of

who did not believe this practice to be unethical, as long as names were not mentioned (Hilbert, 1987).

The reasons for unethical behavior, and the factors which may discourage cheating, should be explored more fully, in order to ensure the most complete inclusion of potential factors. Without a complete understanding of the factors likely to promote or inhibit the incidence of unethical behavior, nursing educators are acting in the dark, with no educated basis on which to make decisions regarding the implementation of preventive measures.

Research has also not yet started to test methods of attempting to reduce clinical unethical behavior, although increased reporting by instructors and the integration of a clinical honor code have been proposed (Davis et al., 1996; Fosbinder, 1991; Hoyer et al., 1991; Jeffreys & Stiers, 1995).

## Statement of the problem to be studied

### Significance

As a profession, nursing has a prescribed Code of Ethics to uphold. In order to maintain and expand upon the respect with which the profession is viewed, nurses must be aware of breaches in ethical behavior by students preparing to enter the profession. Unless nurses are fully aware of the prevalence of such behavior, and the patterns involved, the profession will be unable to design appropriate interventions and preventative practices.

Once nursing students have entered into practice, the implications of unethical behavior become more serious, and may potentially place clients' lives at risk. Therefore, it is important to be able to predict, with some certainty, whether unethical behavior in the classroom is likely to predict unethical behavior in the clinical setting.

### Theoretical framework

A combination of Kohlberg's and Gilligan's theories forms the framework of this study. A child psychologist, Kohlberg (1969) developed his theory of moral reasoning based on

observations of males, children and adults, at various developmental stages. His theory states that individuals progress, from lower to higher levels of moral reasoning, over time, but that this progression is largely individual and unpredictable. There are three levels of moral reasoning in the Kohlberg framework; pre-conventional, conventional, and post-conventional. Each of these levels is made up of two stages, making a total of six stages. Kohlberg used interviews in his research and assigned subjects to various stages or levels of moral reasoning, based on their individual reactions to hypothetical dilemmas (1969).

Because of the largely male samples utilized in the early Kohlberg studies, the framework has been criticized as being biased against females. Gilligan, in a 1977 qualitative study of moral development, using female subjects, found that women made ethical and moral decisions in different ways than did the males in the Kohlberg studies. Based largely on this study, Gilligan developed her own moral reasoning theory (1982), using the Kohlberg levels, and adapting them for use with women. Where Kohlberg's stages are based on justice, Gilligan's levels are based on caring and response towards others. The preconventional level is primarily egocentric; the conventional level is primarily concerned with caring for others; and the postconventional level represents a balancing of care for self and others (Gilligan, 1982). This theory was supported by a study of 80 males and females, mostly under the age of thirty-four (Gilligan & Attanucci, 1988). Gilligan and Attanucci found that both genders used a mixture of justice and caring to solve moral dilemmas, but that females were more likely to use caring as a focus, and males were more likely to use justice perspectives.

Kohlberg has also been criticized for not differentiating between the social conventions of our culture and true moral issues until the higher levels of moral reasoning (Woolfolk, 1995). This is especially important in a society such as the United States, where many other cultural norms are represented.

Another psychologist, Rest (1975), took the major points of the Kohlberg interviews and developed a survey tool, the Defining Issues Test (DIT), to look at levels of moral reasoning. This

tool has been used extensively in many different disciplines (Munhall, 1980; Walker, 1984; Mustapha & Seybert, 1989; Nolan & Smith, 1995; Ferrell & Daniel, 1995). The DIT has also been used repeatedly in nursing research, with mixed results (Cassidy, 1996). Felton and Parsons (1987) found the DIT to be useful for nursing students, and found that advanced levels of education correlated with higher levels of moral reasoning, based on the DIT. Hilbert (1988) and Duckett et al.(1992) also found this tool useful in predicting the moral reasoning level of the student nurse, yet there has been some controversy regarding the use of this theory and tool with nurses, who are largely female (Gilligan, 1982).

Using Gilligan's alternate theory, based on caring, responsibility for maintenance of human relationships is scored at the higher levels of moral reasoning (Gilligan, 1982). In contrast, Kohlberg's stages place justice and fairness at the highest stages of moral reasoning, with caring for others scored at lower levels (Kohlberg, 1969). At least one nurse researcher (Nokes, 1989) has made a plea for a new theory, which combines both Kohlberg's and Gilligan's positions into a framework based on both caring and the balance between competition and cooperation that are necessary to maintain a society. Kohlberg, Levine & Hewer have proposed that Gilligan's levels be incorporated into the original stages, to add depth to the description of moral development (1994). They state, "More than justice is required for resolving many complex moral dilemmas but justice is a necessary element of any morally adequate resolution of these conflicts" (Kohlberg et al., 1994, p. 172).

Kohlberg's theory purports that level of education, or number of years of study, is positively correlated with level of moral reasoning (Kohlberg, 1969). In this study, the researcher investigated the relationship between level of education and the incidence of unethical behaviors. Because cheating falls into low levels of moral reasoning in both Kohlberg's and Gilligan's theories, a negative correlation between these two variables was predicted.

The researcher also gathered data regarding the subjects' exposure, or lack of exposure to an ethics curriculum. According to Kohlberg's theory, more than a single exposure to an ethics

discussion is needed in order to develop a complex understanding of morality (Kohlberg, 1969). Both Kohlberg and Gilligan assert that repeated exposure and discussion of ethics issues is necessary in order to advance to higher levels of moral reasoning (Kohlberg, 1969; Gilligan, 1982). It was therefore expected that exposure to an ethics curriculum would be negatively correlated with unethical behaviors.

Gilligan's and Kohlberg's theories were both utilized in the analysis of qualitative data. The reasons given for participation in unethical behaviors were expected to provide insight into the level of moral reasoning, and the major focus of decision making. Because the majority of nursing students are female, it was expected that reasons provided would primarily focus on care and response considerations, based on Gilligan's theory.

## Assumptions

The assumptions set forth for the study were based on both previous research studies, as discussed in the literature review, and personal experience of the student researcher.

1. Professional nurses make ethical decisions, using reasoning based on previous experiences and education. This reasoning utilizes a mixture of justice and caring considerations.
2. Nurses develop moral reasoning over time, as do all people, and progress to higher levels of moral development in an individual manner.
3. Moral development is dependent on cognitive and sociomoral development, although the presence of these does not always predict higher moral development.
4. Education and exposure to ethical dilemmas provide the necessary impetus for moral development.

## Problem

Although the incidence of classroom unethical behaviors by undergraduate nursing students has been described by several researchers, there has been little documentation of the relationship between classroom unethical behaviors and clinical unethical behaviors. Reasons for unethical behaviors, and deterrents have also not been adequately explored in previous research.

With few exceptions, studies of unethical behaviors by nursing students have focused on baccalaureate students. There have been no studies to date comparing the incidence of unethical behaviors in associate's degree and baccalaureate programs.

Kohlberg's theory proposes that more years of education, and specifically, repeated exposure to ethics curricula, will lead to higher levels of moral reasoning. This has not yet been studied in relation to unethical behaviors by nursing students.

**Research Questions**

(a). Is there a relationship between unethical behaviors in the classroom and unethical behaviors in the clinical setting, among non-graduate nursing students?

(b). What are the reasons and explanations which students give for unethical behaviors, both in the classroom and in the clinical setting?

(c). Is there a difference in the incidence of self-reported unethical behaviors between associate's degree and baccalaureate nursing students?

(d). Is there a relationship between number of years in nursing education and incidence of unethical behaviors?

(e). Is there a relationship between the level of ethical experience and preparation and the incidence of unethical behaviors?

## Objectives

The purpose of this study was to describe the incidence of classroom and clinical unethical behavior by undergraduate nursing students, as measured by self-report, and to describe the relationship between the two types of unethical behavior. The objective of this specific study was to broaden the available knowledge base in this area, by providing data on the behavior of nursing students in rurally-located schools of two different preparation types: Associate's degree and Baccalaureate.

Additionally, exploration was made into the reasons and explanations given by students for

both classroom and clinical unethical behavior. Because there was relatively little data available regarding the possible reasons for unethical behavior, this portion of the study was completed using qualitative methods.

# Chapter III: Study Methodology

## Research Design

The design of the study was a descriptive exploratory survey. This study used descriptive, correlational, and inferential statistics. A survey tool was used to gather data by self-report, utilizing both quantitative and open-ended qualitative questions. This design was proposed in order to obtain the widest possible frame of knowledge regarding the occurrence of unethical behaviors in undergraduate nursing students.

## Research Hypotheses

1. Research question: Is there a relationship between unethical behaviors in the classroom and unethical behaviors in the clinical setting, among non-graduate nursing students?

Hypothesis: There will be a positive correlation between unethical behavior in the classroom and unethical behavior in the clinical setting, as measured by self-report.

Literature support: Previous studies have shown a positive correlation between these two types of unethical behavior, using urban undergraduate nursing students (Hilbert, 1985; Hilbert, 1987). This study chose students from rural non-graduate nursing programs and attempted to replicate the findings in the Hilbert studies.

2. Research question: What are the reasons and explanations which students give for unethical behaviors, both in the classroom and in the clinical setting?

Hypothesis: None.

3. Research question: Is there a difference in the incidence of self-reported unethical behaviors between associate's degree and baccalaureate nursing students?

Hypothesis: There will be a difference between associate's degree and baccalaureate prepared nursing students, in the total incidence of unethical behaviors.

4. Research question: Is there a relationship between number of years in nursing education and incidence of unethical behaviors?

Hypothesis: Subjects with more years of education and more nursing education will report fewer

Kohlberg's theory of moral development, have found that subjects with more advanced educational levels, and/or more exposure to ethics curricula, tend to show higher levels of moral reasoning, when measured by Rest's DIT tool (Rest, 1975; Mustapha & Seybert, 1989).

5. Research question: Is there a relationship between the level of ethical experience and preparation and the incidence of unethical behaviors?

Hypothesis: The level of ethics preparation a given subject reported will be inversely correlated with overall unethical behaviors. Support for this hypothesis, based on literature review, is the same as that given for hypothesis number 4.

## Variables

The dependent variables of interest in this study were self-report of (a) classroom unethical behavior, and (b) clinical unethical behavior. These were measured by number of times each behavior was reported to have occurred in the current academic year. An additional variable, (c) total unethical behaviors, was derived by adding clinical and classroom behaviors for each subject.

Independent variables of interest included (a) total number of years in post-high school education, (b) number of years in nursing education, (c) type of nursing program in which subject was enrolled (associate's or bachelors's degree), (d) current or previous enrollment in an ethics course, (e) awareness of an honor code and (f) perceived level of preparation for dealing with ethical dilemmas in nursing and nursing education. Theoretical and operational definitions are presented in table 1.

Qualitative data collection was designed to discover the stated reasons for unethical behavior occurrences. Additional variables may be discovered during the analysis of qualitative data obtained. According to Brink and Wood, "Theory is sometimes developed on the basis of content analysis of unstructured data, frequently resulting in concepts and operational definitions" (1978, p. 145).

**Table 1: Theoretical and Operational Definitions**

| Concept | Theoretical definition | Operational definition |
|---|---|---|
| Classroom unethical behavior | Unauthorized behaviors, occurring in the classroom setting, which are perceived as dishonest or fraudulent by the faculty and administration of the given institution (Hilbert, 1985). | Score >0 as measured by the following items on the Hilbert Unethical Behaviors Survey (HUBS): 1, 3, 5, 7, 9, 11, 13, 15, 17, 19, 21 |
| Clinical unethical behavior | Unauthorized behaviors, occurring in the clinical setting, which are perceived as dishonest or fraudulent by the faculty and administration of the given institution(s) involved (Hilbert, 1985). | Score >0 on the following items on the Hilbert Unethical Behaviors Survey (HUBS): 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22 |
| Incidence of unethical behavior | Unauthorized behaviors, which occur either in the classroom or in the clinical setting (Hilbert, 1985). | Percent of respondents who admit unethical behavior in any setting. The total number of scores, (classroom unethical behavior + clinical unethical behavior) on all items of the HUBS, divided by the total number of respondents. |
| Post-secondary Educational Experience | Number of years of post-high school education. "Higher education sometimes encourages reflection on, and discussion of, social and moral issues which may impact upon moral development" (Walker, 1990, p. 116). Cognitive development is theorized to be a prerequisite for moral development (Kohlberg, 1969). | Total number of years in post-high school education, to be entered on the demographic page. |

| Concept | Theoretical definition | Operational definition |
|---|---|---|
| Nursing education experience | Number of years engaged in nursing education in the student role. Nursing students are theorized to learn from repeated exposure to the ethical dilemmas of nursing education (Hoyer et al., 1991). | Number of years in nursing education and year in program (first or second year in Associate degree program; junior or senior in Baccalaureate program), to be entered on the demographic page. |
| Level of ethical experience and preparation | Exposure to repeated role-taking experiences and ethical decision making is theorized as the impetus to moral development (Kohlberg, 1969; Kohlberg et al., 1994; Blatt & Kohlberg, 1994). | Present or previous exposure to an ethics course, entered on the demographic page.<br>Perceived level of preparation for ethical decision making. Measured by semantic differential with a forced choice (five levels) on the demographic page. |
| Moral development | The relative importance a subject gives to principled moral considerations in making a decision about moral dilemmas (Rest, 1975; Rest, 1979). | Perceived level of preparation for ethical decision making. Measured by semantic differential with a forced choice (five levels) on the demographic page. |

**Instrumentation**

The major instrument chosen for this study was the Hilbert Unethical Behaviors Survey (HUBS) tool (Hilbert, 1996). This tool had the advantage of being both easy for subjects to understand and complete, and simple to score. This instrument had previously been used repeatedly, by several nurse investigators (Hilbert, 1985; Hilbert, 1987; Hilbert, 1988; Alexander, 1992; Scheer, 1989), providing mounting evidence for the reliability of the tool.

Hilbert (1985) used coefficient alpha as a measure of internal consistency of the items on the HUBS tool in her study of baccalaureate nursing students. The resulting coefficient was 0.668 for her study. Hilbert admits, "the use of coefficient alpha may not be appropriate, because this scale was criterion-referenced rather than norm-referenced (Hilbert, 1985, p. 231)". According to Waltz, Strickland and Lenz (1984), "In the criterion-referenced framework, reliability is usually estimated by employing test-retest, parallel-form and intrarater and interater agreement procedures (p. 188)." For purposes of this study, none of these recommended procedures could be performed, due to restrictions of time, money and personnel. In attempt to further support the reliability of the tool, the researcher ran coefficient alpha reliability estimates on the data gathered in the study, the same method used by Hilbert previously. The resulting coefficient was .5715. Caution must be employed in interpretation of data using this instrument, as Polit and Hungler (1995) state, "[Although] there is no standard for what an acceptable reliability coefficient should be. . . instruments with a reliability of .60 or lower are risky to use (pp. 352-353)."

A major difference in the use of the HUBS tool for this study, compared to previous studies, is the rural nature of the area from which the sample was chosen. The tool was developed and used on urban-based populations in all the prior studies. Details regarding possible reasons for the low reliability estimate obtained in this study will be included in the discussion chapter.

Two additional open-ended questions originated by this researcher were included with the HUBS tool, for the purpose of gathering data regarding reasons for unethical behaviors. These items are included in Appendix D.

The demographics information gathered on subjects included a school code, the number of years of education since high school, and class standing (first, second or third year of nursing education). To ensure subject's confidentiality, no name, gender, age or ethnic background data was collected.

**Assumptions / Limitations**

The major assumption of this study was that nursing students would be honest in their self-report of unethical behaviors. Subjects were assured of anonymity of results. Because of the sensitive and social undesirability of admitting to involvement in unethical behaviors, such as unethical behavior on tests and assignments and falsifying patient records, nursing students may be unwilling to admit involvement, even with anonymity assured. In past studies, this has led to serious underreporting (Scheers & Dayton, 1987; Daniel et al., 1994).

The instrument used for this study also constituted a limitation for this study. Reliability estimates were low on this tool, making the results suspect. As previously mentioned, this tool had never before been tested on rural-based population samples. Some of the items may not have had meaning in the rural context. Specific examples of items that are suspect will be discussed in the last chapter.

An additional limitation of this study was that of geographic location. Although all subjects were students in rurally-located nursing schools, these schools were all located in one general geographic area, the Del-Mar-Va peninsula. This area may or may not have been representative of other rural areas in the United States. Because subject selection in the study was non-random, the results are not generalizable to all nursing students.

## Study Population

**Population**

The target population for this study was nursing students enrolled in rurally located undergraduate schools of nursing.

**Sample characteristics**

The sample was obtained from three different schools of nursing, all located in the rural area known as the Del-Mar-Va peninsula. Two of the schools were associate's degree preparation programs, Delaware Technical College and Wor-Wic Community College, located in Delaware and Maryland, respectively. The remaining school was a baccalaureate preparation program, also located in Maryland, Salisbury State University.

Convenience samples, consisting of intact classes, were used from each of the schools. An attempt will be made to include both first and second year students from each program, in order to obtain the largest possible sample.

**Sample size**

The researcher sought to obtain at least 50 subjects from each of the schools, to make a total sample of 150 subjects. This would allow the greatest possible versatility in statistical analysis of data. This goal was met in regards to the two associate's degree schools, and exceeded in regards to the baccalaureate school, where seventy-seven subjects were obtained, yielding a total of 177 subjects.

## Data collection

Data collection was completed entirely by the researcher, who visited each school on a predetermined day and administered the survey tool to intact classes, for collection during the same class period. Permission was obtained from both administration and individual faculty members prior to data collection. Administrative permission letters are included in Appendix E. Students not wishing to participate in the study were given the opportunity to use this time to study. None of the students chose this option, and 100% participation was achieved. Estimated time for tool completion was 20 minutes, according to Hilbert (1985). The actual time of completion ranged from 8 to 18 minutes.

Full disclosure of the purpose of the study was given to the students, and assurances of

anonymity explained by the researcher, prior to distribution of the instrument. Copies of the disclosure statement and the tool used are included in Appendix E.

The HUBS version included in the appendix is the 1996 version. The last page, developed by Hilbert to identify possible causes of unethical behaviors, was omitted because it provided choices to the respondent that could influence the results of the qualitative questions. The researcher substituted two open-ended qualitative questions in place of the omitted page for the current study.

Demographic data collected from the subjects included number of years of post-secondary education, number of years of nursing education, class standing, ethics preparation, and knowledge of school honor code. Actual school honor code information and penalties for unethical behavior was obtained from school catalogs from each of the participating institutions for purposes of comparison.

## Data analysis

The data collected from the HUBS is in the form of actual numbers of incidents, which are continuous ratio measurements. Therefore, to look for a correlation between classroom and clinical items, the statistical procedure used was the Pearson's product-moment correlation coefficient. This method was also utilized to look for correlation between the number of years of nursing education and the total number of unethical behaviors reported.

Demographic data collected on the subjects was nominal or ordinal in nature, while incidence data collected was ratio level. Therefore, a two-sample T test was used to analyze the differences between the schools with respect to incidence of unethical behavior. Data analysis of the relationship between level of ethics preparation and unethical behavior utilized Spearman's correlation.

Analysis of the qualitative data received involved extensive comparisons of items and

searching for common themes using content analysis. According to Polit and Hungler (1995), "Content analysis involves the quantification of narrative, qualitative material" (p. 195). This process involves searching for common words, themes or items in the data, using consistently applied selection criteria (Polit & Hungler, 1995; Brink & Wood, 1978). There was no preconceived notion in the mind of the researcher regarding what would be the nature of the findings. Data gathered in this fashion may conform to one of the existing theories regarding moral reasoning, or may require the formation of a new model to explain the findings.

# Chapter IV: Results

## Hypotheses

1. Research question: Is there a relationship between unethical behaviors in the classroom and unethical behaviors in the clinical setting, among non-graduate nursing students?
Hypothesis: There will be a positive correlation between unethical behavior in the classroom and unethical behavior in the clinical setting, as measured by self-report.

Pearson's product-moment correlation was used, with the total number of classroom behaviors and the total number of clinical behaviors obtained. A non-significant correlation of .094 was obtained. The researcher then utilized the less powerful Spearman's rank-order correlation, with the same data. This time a correlation of .383 was obtained, which was significant at the p=.01 level. (See Table 2.) This unusual difference in significance between the two correlation tests was investigated further by the researcher. When a scatterplot was performed on this data, a couple of outlier data points deviated from the linear trend displayed by the remaining points. This in turn lowered the Pearson's correlation coeficient. These outliers did not affect the Spearman's correlation as drastically because the Spearman's correlation is based on the ranks of the data . Once the most extreme outlier was removed, the Pearson's r result was significant at the p=.01 level. The extreme data point removed was a response of 99 in regards to a classroom unethical behavior (plagiarism).

Based on this result, the data obtained in this study do support a relationship between behavior in the classsroom and in the clinical setting.

2. Research question: What are the reasons and explanations which students give for unethical behaviors, both in the classroom and in the clinical setting?
Hypothesis: None.

Twenty-six percent of respondents gave detailed answers to the qualitative questions on the survey tool. Actual qualitative findings and analysis will be discussed in the next section of this chapter.

Table 2

**Correlation between unethical behaviors in classroom and clinical settings (Spearman's)**

| | Clinical behaviors | Sig. (2-tailed) |
|---|---|---|
| Classroom behaviors | .383 | .000 |

3. Research question: Is there a difference in the incidence of self-reported unethical behaviors between associate's degree and baccalaureate nursing students?

Hypothesis: There will be a difference between associate's degree and baccalaureate prepared nursing students, in the total incidence of unethical behaviors.

A two-tailed t-test was performed on the data obtained, comparing the means of the baccalaureate students, from Salisbury State University, from the associate's degree students, combining data from Delaware Technical College with that obtained from Wor-Wic Community College. Although the two means did differ slightly, the difference was not significant. (See Table 3). Therefore, no support was found for this hypothesized difference in unethical behaviors between associate's degree and baccalaureate programs.

4. Research question: Is there a relationship between number of years in nursing education and incidence of unethical behaviors?

Hypothesis: Subjects with more years of education and nursing education will report fewer overall unethical behaviors, as measured by the HUBS tool.

Spearman's rank-order correlation was performed, using the total number of years of post-high school education, and the total number of unethical behaviors. A correlation of .193 was obtained, a figure which was significant at the p=.05 level. The correlation, however, is a positive one. Therefore, data from this study does not support this hypothesis, and does lend support to a completely opposite finding, that unethical behaviors increase as educational preparation increases. It is interesting to note that subjects from the two associate's degree schools reported a median of about 2.0 years of post-high school education, with Salisbury State students reporting a slightly lower median of 1.75 years.

Both Spearman's rho and Pearson's product moment correlation were performed, using number of years of nuring education, and the total number of unethical behaviors with no significant correlation found. (See Table 4). No support for the hypothesis that unethical behaviors would decrease as educational preparation and number of years of nursing education

Table 3

**T-test of Total behaviors, by type of school**

| Type of school | N | Mean | F | Sig. |
|---|---|---|---|---|
| Associate's | 100 | 6.60 | .008 | .928 |
| Baccalaureate | 77 | 8.49 | | |

Table 4

**Correlations between selected subject characteristics and total unethical behaviors**

| | Total behaviors | Significance |
|---|---|---|
| Post H.S. education (# yrs.) | | |
| **Spearman's** | **.193** | **.011** |
| Pearson's | .061 | .425 |
| Nursing education (# yrs.) | | |
| Spearman's | .129 | .093 |
| Pearson's | .094 | .211 |
| Ethics course exposure (yes/no) | | |
| Spearman's | -.055 | .466 |
| Ethical preparation (ordinal meas.) | | |
| Spearman's | -.088 | .246 |
| Honor code awareness (yes/no) | | |
| Spearman's | -.016 | .832 |

**Bold type indicates significance**

increases was found from the data.

5. Research question: Is there a relationship between the level of ethical experience and preparation and the incidence of unethical behaviors?

Hypothesis: The level of ethics preparation a given subject reported will be inversely correlated with overall unethical behaviors. Data analysis involved two separate correlations, using self-report of exposure to an ethics course and self-report of level of ethical preparation, both individually correlated with total unethical behaviors.

Self-report of ethical preparation was compared with total unethical behaviors. Using Spearman's rho, a negative correlation of -.088 was obtained. This result was not statistically significant. No support was obtained for the hypothesis that the level of ethical experience and preparation a given subject reports would be inversely correlated with total unethical behaviors.

## Qualitative data analysis

As previously mentioned, twenty-six percent of subjects provided detailed answers to the qualitative questions on the instrument. These answers ranged in length from one or two word responses to four and five sentence paragraphs. Some students spoke about their own cheating, but more often they gave examples of cheating they had observed by other students, and gave suspected reasons. The main purpose of including a qualitative portion in this study was to attempt to obtain information about reasons for unethical behavior from those most likely to know about those reasons first hand. Because only 26% of the respondents answered the qualitative questions, and many of these did not provide answers which described their own participation in unethical behaviors, an unknown portion of potentially valuable data is missing here.

### Classroom behaviors

The type of unethical classroom behavior most often mentioned in the literature, that of cheating on tests, was also the most mentioned in the qualitative data obtained in this study. Of the forty-six subjects who gave detailed answers, twenty-nine made some comment about cheating on

tests. Those subjects who reported cheating themselves gave little or no insight into the reasons for this behavior. As one student respondent states, "When guilty of this [giving and receiving test answers] I have never been sure of the reason." Many of the students who responded in this area seemed to express the belief that cheating on quizzes or ungraded assignments is excusable or even expected. This distinction was most often noted by the Salisbury State students. Several quotes are included here for clarity;

"I've copied quiz answers when I haven't read or when the quiz doesn't count."

"I have let my good friends know a couple of answers on quizzes but I've never let anyone copy off of me on an exam."

"Gave answers to quizes or asked for answers on a pop quiz in front of the instructor, most of the class did this it became a group project."

"Discussed answers about a pop quiz. Reason's - not knowing the information."

"On one occasion an answer was given to me by another student who had previously taken the quiz. I did not ask for the answer, she had given it freely - but I did use the information. It was not in a Nursing class, it was a class that was required for the curriculum."

"If asked about the answer to a question, I will give the answer I chose. It would not make a difference anyway this is not competition."

In a few cases, students did admit to cheating on tests, and their responses offer some insight into the reasoning involved. There is anger, both expressed and implied, in the responses of these students. One student stated, "Medsurg exams are usually too difficult to be fair."

Another reason, stated by three students, in different ways, is simple lack of preparation. As one of these wrote, "[I] Didn't know the information at all." Still another student expresses the ease of cheating, "There is alot of pressure in getting good grades and when you don't know the answer to a question on a test, it is easy to cheat from someone else." This sentiment is expressed by subjects from two of the schools, Del Tech and Salisbury State. One student, who reported having copied test answers, stated only, "Temptation" as the reason. Another subject describes a specific incident;

> Our desk are very close together and I looked up and saw the person's next to me paper, I couldn't seem to look away, we had the same answer on 2 questions but one was different and I changed mine.

One student gives no reasons for cheating on tests, stating only, "I was put out of school" when caught.

Several students, from all three of the schools, admitted to giving answers to classmates, for the reasons described in this quote from a student, "I felt bad for a friend who made 'D''s & 'E''s on tests in Developmental Psychology. I tapped him and pointed to my answers and he copied some and got a "B" on his test." Another student expressed nearly the same reason, "A friend was in danger of failing a class. Let friend look at my test."

There is also expressed anger by many of the subjects, regarding a system that they perceive as too permissive of cheating. This was a recurrent theme among many of the students, with fully 72% of those who provided detailed answers making some comment about test cheating and the exam testing system at their institution. One student, who reported having allowed others to copy answers, states;

> "I didn't participate myself, but I believe that there is a prevailing attitude that if we are given unreasonable, <u>invalid</u> questions we have an unstated <u>right</u> to try to do as well as we can- getting answers from other students under auspices of a "review" seemed perfectly legitimate (& still probably does to most.) Certainly professors knew that questions were

being copied down (I don't think it matters to what extent). I'm just as disappointed in the professors as I am in the students. Make new damn questions!"

Another student from the same school reports getting test questions and answers from another student, and describes an incident;

"One time we had a student in our class receive the questions for a test from another student who had previously taken the test. The faculty was aware of the incident and no action was taken."

One expressed some irony in explaining about giving answers to a fellow student, "Someone looked at me and wanted an answer to a question. I showed them my answer sheet. But we both got it wrong because I had it wrong!"

When subjects expressed assumed reasons for the unethical behavior of classmates, their responses mostly related to lack of preparation. One student also discussed fear, "I think classroom cheating comes from fear, fear of failing and fear of appearing inadequate." Another student mentioned moral values self-reliance, describing unethical classroom behaviors as being due to, "Lack of moral values and belief. Simply unsure of self and reliant on others. Poor preparation and [unreadable response]."

The second most common unethical classroom behavior commented on by subjects, is that of plagiarism. The reasons expressed for this behavior are mostly related to either lack of knowledge regarding the correct way to reference a term paper, or lack of time to obtain proper sources. Several students are quoted as examples;

"[I] took someone's ideas without quoting them because my paper was full of quotes already."

"[My problem is] not referencing- usually not aware of a better way to say it, then unsure how much to reference."

"[I] couldn't figure out or didn't have time to put answers in my own words, so I just copied the passage to use as my own."

**Clinical behaviors**

The clinical behaviors which are most likely to impress or frighten patients and the public; coming to clinical under the influence of drugs and/or alcohol, theft of medications or property, and charting medications or treatments which were not completed, were largely unreported in this sample. Only two detailed comments were received regarding drug and alcohol use by students. One subject stated, "Prescribed daily Paxil, Ativan," in explaining the self-report of coming to the clinical area under the influence of drugs and/or alcohol. The only other comment received regarding this area was a denial statement; "I do not believe in using drugs. I am an occassional drinker, but never before, or during, school or work."

The clinical behaviors most reported in this study were calling out sick for clinical when not ill, and talking about clients in public places or with non-medical personnel. Only one comment was received regarding calling out sick when not ill; "You are allowed 10 hours sick time for clinical, so I took a day for myself." Ten subjects wrote comments about client confidentiality, mostly defending the practice of discussing patients with non-medical personnel, as long as names are not used. Quotes from several subjects are included to illustrate;

"Discussing pts with spouse although I never reveal name I almost always discuss what happened to me during clinical."

"not pt. names."

"Shared pt. info, [but] would not say I had cheated in clinical."

"Talking about pt's in other areas is my problem."

The implication here is that the students chosen for this study do not see sharing patient

information as an unethical behavior, when names are not included. Hilbert (1987) also found this to be true in her study, and speculated that this item might need to be reworded or eliminated from future versions of the HUBS instrument. This change to the instrument was never made.

Only one subject in this study reported having used a client's name, stating, "discussed pt with spouse. spouse knew the pt."

Several subjects commented on the item regarding charting medications or treatments that were not completed. These comments were sometimes confusing, as in this example, "The only mis-information I've seen is related to promoting patient care by achieving the immediate priority." Other subjects seemed to imply that mis-charting should not be considered unethical behavior;

> "I think that clinical cheating would be hard to do unless you sign material or interventions off that you don't do and in this case it's laziness and irresponsibility not cheating."

Two of the qualitative comments received are from subjects who report having charted treatments which were not completed. Both of these students imply that they had to do this in order to look good to the clinical instructor and receive a good grade;

> "I have before charted things that were to the pt. by a staff nurse & kind of made it look like I did it, just to make sure it looked good to the teacher, like I was really a competent."
> "I made up a client for my care because I had not done any teaching to the other clients. The nurses and nutritionists had done it all."

The last of the clinical behaviors mentioned, in the qualitative answers received, was theft of hospital property. Five subjects commented in this category, with two of them reporting theft of scrubs. No reason was given for taking the scrubs in either case, one student saying only, "wanted a pair of scrubs." The other subject wrote in more detail; "I think that stealing from clients, hospital would also be cheating even though I am guilty of taking scrubs!" Two other subjects reported having taken small items from the hospital, tegaderm and tape. The fifth response was a more detailed answer, describing an incident involving another student;

> "STUDENT NURSE stole credit cards from a fellow classmate. After investigation she

was arrested and subsequently dropped from program."

Although this comment is not truly self-report, it does show that the subject was concerned by this behavior or the consequence.

One additional qualitative response occurred repeatedly. On many of the questionnaires, from all three schools, subjects wrote "N/A" or the equivalent under one or both of the qualitative questions regarding unethical behaviors. This was not considered to be a detailed answer by the researcher, yet the finding did provide some insight into the thoughts and values of the subjects, as will be further discussed in the next section.

## Other findings

A number of unexpected significant correlations were found during data analysis. Some of these serve merely to describe the sample, others may assist in describing the phenomenon of unethical behaviors among nursing students, or in the development of theory.

Because all twenty-two items of the HUBS were analyzed, using ANOVA in an ex post facto analysis, the error rate is potentially very high for these results. They do, however, help to explain some of the other findings in this study, and suggest directions for future research.

One of the most surprising of the unforeseen findings involved the comparison of means, across schools, in regards to number of years of nursing education reported. The baccalaureate students reported themselves as having the fewest years of nursing education. See Table 5 for a detailed comparison. This may be because the students at Salisbury State are not considered "nursing students" until they enter their junior year of college, thus these students perceive themselves as having fewer years of nursing education than do the associate's degree students.

It is interesting to note that the baccalaureate students also reported themselves to be less prepared to make ethical decisions (median score of 3.0) than did the associate's degree students (median scores of 4.0, both schools). This seems to contradict the popular view that the baccalaureate degree prepared student will be more prepared for practice decisions than the associate's degree student, upon graduation. Traditionally, baccalaureate students tend to be

younger than associate's degree students, and this may have some bearing on their confidence in their own decision making skills. No data were collected regarding the actual age of the student participants in this study.

Although total unethical behaviors, compared by schools, did not show a statistical difference, there was a significant difference on four of the individual items from the HUBS instrument. Item number 2, 'Calling in sick for the clinical area or work when you were not', was more likely to be answered with an affirmative response by students from Wor-Wic Community College. It is unclear whether this is related to a policy difference between this school and the others or a difference in student attitudes.

Using ANOVA, the behaviors measured by items number 3, 21 and 22 were more likely to be reported by the Salisbury State University students studied. Item 3, 'Copying from someone else's exam or quiz paper or receiving answers from another student during an exam or quiz' showed the most significant difference in comparison of means. As previously discussed, in the qualitative data analysis section, this was also a recurrent theme in the comments of student subjects.

Comparing the overall findings of these ex post facto analyses, it appears that one type of nursing school (baccalaureate) tends to be more likely to report certain types of behaviors, such as cheating on exams. Associate degree schools were not analyzed collectively in this procedure, yet it appears that asscoiate degree students are more likely to report calling in sick for clinical. It is possible that these differences in type of behaviors reported cancelled one another out when total unethical behaviors were compared by type of school (Hypothesis 3).

One additional qualitative comment, not previously mentioned, was written in the margin of a questionnaire. This comment related neither to classroom or clinical behaviors, but to the data collection process itself. The subject circled the word 'anonymous' on the disclosure statement and wrote, "Next time - allow for privacy, other students were watching for remarks." This subject was a Salisbury State student. Although all data collection occurred in intact classes, in the

same rooms used for both lecture and testing of these classes, the SSU classrooms were the smallest, allowing for little space between desks. It is possible that use of a larger classroom would have produced more detailed qualitative findings and greater reporting of unethical behaviors on the HUBS. Because of the social consequences involved in self-report of unethical behaviors, under-reporting is a strong possibility.

Although there was no hypothesis relating to the information collected on the demographic page regarding knowledge of school honor code, this information proved interesting to the researcher. There was not a negative correlation found between knowledge of the school's honor code and total unethical behaviors. Knowledge of the school's honor code alone is clearly not enough to deter cheating, since more than 92% of subjects, from all schools, expressed knowledge of the school's honor code, yet 67% of the subjects reported at least one unethical behavior.

Many of the subjects wrote the comment "N/A" under one or both of the qualitative questions. Although this was not an operationally defined variable, the researcher was interested to find that nine percent of the total respondents wrote this comment, and that many of these subjects had also reported unethical behaviors on various HUBS items. The items most often reported in connection with this qualitative comment were item number 2, "Calling in sick for the clinical area or work when you were not," and item number 18, "Discussing patients in public places or with non-medical personnel." The implication suggested by this finding is that the subjects did not believe these behaviors to be unethical. Hilbert (1987) also found that many subjects did not consider these same items to constitute unethical behavior, and suggested that the instrument might need revision in this area.

Table 5

**ANOVA between groups, by school***

| | Schools | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | Sig. of linearity |
| Nursing education (in years) | | | | |
| Mean | 2.119 | 2.275 | 1.756 | .036 |
| Median | 2.000 | 2.000 | 1.750 | |
| HUBS item 2,"Calling in sick for the clinical area..." | | | | |
| Mean | .40 | .10 | .17 | .011 |
| Median | .00 | .00 | .00 | |
| HUBS item 3, "Copying from someone else's exam or quiz..." | | | | |
| Mean | .08 | .00 | .48 | .010 |
| Median | .00 | .00 | .00 | |
| HUBS item 21, "Working with another student on an assignment..." | | | | |
| Mean | .08 | .14 | .47 | .042 |
| Median | .00 | .00 | .00 | |
| HUBS item 22, "Failing to provide information to a patient..." | | | | |
| Mean | .06 | .00 | .34 | .047 |
| Median | .00 | .00 | .00 | |
| Level of ethical preparation (ordinal scale of 1=totally unprepared to 5=totally prepared) | | | | |
| Mean | 3.595 | 3.724 | 3.201 | .009 |
| Median | 4.00 | 4.00 | 3.00 | |

Legend

1 = Wor-Wic Community College
2 = Delaware Technical College
3 = Salisbury State University

*All 22 items of the HUBS were analyzed ex post facto, increasing the error rate for this analysis

## Chapter V: Discussion

### Meaning of findings, in relation to hypotheses

Although the HUBS tool attained a low reliability estimate as used in this study, there are still a few significant findings to discuss, as related to the hypotheses. The first hypothesis, that clinical and classroom behaviors are positively correlated, found support in the data from this study. Although a significant relationship was found, the actual correlation of .383 shows a weak relationship. This hypothesis was also supported by at least two previous studies (Hilbert, 1985; Hilbert, 1987). This finding suggests that nursing students who act in unethical ways in the classroom are more likely to act unethically in the clinical setting. The implications could be far reaching, as these students will presumably enter independent clinical practice after graduation. Future study into the unethical behavior patterns of these same subjects, several months into clinical practice, could prove very interesting.

The premise that subjects would be willing to respond to the qualitative questions in this study was supported by the volume of detailed answers received, and the rich detail included in those replies. Considering the social implications involved in admitting to unethical behaviors, even the low response rate of 26% is encouraging. The research question related to this hypothesis, "What are the reasons and explanations which students give for unethical behaviors, both in the classroom and in the clinical setting?", was partially answered by this study. This study did clearly show that there were reasons for these behaviors, which some of the students were willing and able to express. A future study including open-ended questions, such as those used in this study, could perhaps yield more insight and obtain longer, more detailed answers, if administered in larger classrooms, with more space between desks, for privacy of the subjects.

There was no support found in this study for any of the remaining hypotheses. None of the subject traits chosen for this study provided any predictive correlation with unethical behaviors. The only exception to this lack of significance was that of post-high school education as a predictive factor. This factor was found to predict in a direction opposite of the hypothesis. In

other words, based on the data from this study, the more educated subject was more likely to engage in unethical behaviors, or at least more likely to report them. One possible implication is that the educational process is actually serving to socialize and/or teach students about unethical behaviors. Perhaps this could have something to do with negative role models, seeing other students getting better grades and "getting away with" cheating. Another possible implication is that more education leads to greater honesty in self-report of socially undesirable behaviors.

The fact that the other subject traits chosen were not predictive in this study implies that either these reasons are not related at all to unethical behavior, or that the reasons and causes are more complex, involving the interplay of several factors. Further discussion of the latter possibility is included in the last section of this chapter.

## Implications and suggestions, based on qualitative data

The qualitative data obtained provides insight into environmental modifications which could have an impact in reducing the incidence of unethical behaviors. The first modification suggested is that of ensuring that the students are aware of what behaviors are considered unethical by a given institution and instructor. Many of the subjects in this study did not believe that cheating on quizzes was unethical, for example. Knowledge of the school's honor code alone is clearly not enough to deter cheating, since more than 92% of subjects, from all schools, expressed knowledge of the school's honor code, yet 67% of the subjects reported at least one unethical behavior.

Another major modification suggested is placing desks farther away from one another during testing, to reduce the temptation to cheat. Several subjects mentioned the ease of cheating on tests, due to close proximity. This may be difficult to achieve in small classrooms, where staggered testing may be necessary to maintain honesty.

Provision of positive role models is suggested by the number of subjects who described seeing other students "get away with" cheating on tests. Perhaps previous graduates, or honor society members could be enlisted as preceptors for beginning nursing students, in order to provide a positive model for study habits and classroom behavior.

Plagiarism was reported by many of the subjects, and the comments included provide some insight into possible reasons. Several students expressed a lack of knowledge regarding proper citing of references. Perhaps a useful suggestion would be to provide a few handouts with examples for student use. It is possible that some students cannot afford an APA manual, or have limited time to spend in the library. A desk copy of the APA manual might prove helpful in answering questions as they arise in the classroom.

Relatively few comments were received regarding clinical behaviors, but the behaviors most likely to be engaged in were calling in sick and discussing patients inappropriately. Perhaps schools of nursing need to make the rules and consequences more apparent to students. If these behaviors are not considered unethical by the students, as previously discussed, then perhaps the instructors also do not consider them unethical, or have not expressed their beliefs to the students. Carmack (1984) conducted a qualitative study of nursing instructor's attitudes toward plagiarism. Perhaps further studies of this type, regarding other classroom and clinical behaviors, could yield important information regarding the values held by nursing instructors, which are being taught and/or modeled for the students.

Some students also expressed the belief that charting procedures or medications that were not actually completed should not be considered unethical, but merely laziness. Perhaps the use of role playing methods, with each student taking a turn as the patient, might help students understand why this behavior is considered to be unethical, even illegal, by most nurses and nursing instructors. If these students have limited experience as patients, perhaps they do not realize that being denied a medication or treatment could be frustrating or harmful to the patient.

Many students mentioned theft of hospital equipment, especially scrubs, yet they seemed to be aware that this was unethical behavior. A discussion of hospital policies regarding theft might be of some use in deterring this. It is unclear, based on this study, how many students would persist in theft regardless of hospital policy. Perhaps a signed agreement between each student and the clinical institution might be helpful in increasing responsible actions.

## Significance

Although the reasons and explanations for unethical behavior found in this study do not comprehensively answer the question of why nursing students participate in unethical behaviors, they do begin to describe the phenomenon. Given the results of this study, future researchers should have a better idea of questions that are likely to produce the best results in rural populations.

Based on the qualitative results of this study, it is clear that few nursing students are willing and/or able to explain reasons for their unethical behaviors. Seventy-four percent of the respondents did not provide anwers to the qualitative questions. Further study, providing more privacy for the subjects is suggested.

The qualitative responses received in this study do provide a beginning understanding of factors which are likely to increase the incidence of classroom and clinical unethical behaviors. Suggestions for nursing instructors, to reduce the incidence of unethical behaviors, through environmental manipulation, are included.

## Limitations

### Instrumentation

The quantitative findings in this study were clearly limited by the reliability of the tool used. When a reliability estimate was run on this tool, a low alpha coefficient result was obtained. Analysis showed that two of the HUBS items, numbers 9 and 15, were consistently answered with zeros by all subjects. Because this tool was developed and used exclusively in urban areas previously, a question is raised about the usefulness of the tool with rural populations. Perhaps these two items in question are not prevalent behaviors in rural settings and should be omitted from the instrument for rural applications.

HUBS item number nine reads, "Taking an exam or quiz for another student." Perhaps this behavior is simply not possible in the rural environment, where classes are smaller, and students are personally known to their instructors. In fact, the researcher found that, in all of the schools included in this study, nursing theory class size is limited to less than thirty students, and

clinical groups are smaller yet. It would clearly be difficult to take a test for another student in these small groups.

HUBS item number 15 reads, "Turning in a paper purchased from a commercial research firm." This behavior also may be limited by unavailability in the rural environment. In large schools of nursing, where student volume is high, there is a more lucrative environment for commercial firms to develop and exist. Small schools in rural areas probably offer less potential financial gain for these firms, and thus are less likely to attract them. Certainly there were no advertisements for commercially produced papers on any of the bulletin boards, or in any of the school newspapers of the schools studied.

An additional potential problem with the instrument used is that two of the items, numbers 2 and 18, correlated significantly with the qualitative comment, "N/A". The implication is that the subjects did not consider these behaviors to be unethical. Item number 2 reads, "Calling in sick for the clinical area or work when you were mot." Item number 18 reads, " Discussing patients in public places or with non-medical personnel." This finding replicates a similar result by Hilbert (1988), and suggests that these items should be modified or removed from the instrument for future research. Hilbert also made this suggestion in 1987, but the instrument was never revised.

**Sample**

The sample chosen for this study was obtained by using the method of convenience sampling. Because the subjects were not obtained randomly, the generalizability of the findings is limited. Obtaining a random sampling of all rurally located undergraduate nursing students in the United States would be a costly and extensive project, but would greatly improve the validity of the findings.

**Data collection**

Data collection was completed by the researcher in a method that was as uniform as possible, across groups. One external variable, which could not be controlled, was the size of the classroom utilized and the spaces allowed between the subjects' desks. This was a potential threat

to the anonymity of the subjects and may have caused some subjects to modify their replies. The school most affected by this external threat was Salisbury State University. These classrooms were the smallest of the three schools studied. It is interesting to note that a larger percentage of SSU students provided detailed answers to the qualitative questions than either of the other schools. It is suggested that a more private data collection method would have improved the low response rate to the qualitative questions.

Self-report of unethical behaviors did not prove to be a significant predictor of detailed answers to the qualitative questions. Presumably there were a number of subjects who were willing to admit to unethical behaviors, but were unwilling or unable to explain the reasons for these behaviors. It is unclear whether a different data collection method would have retrieved more information. Personal interviews may have been more intimidating to many of the subjects, and mailings usually have a much lower response rate (Polit & Hungler, 1995).

## Future research; a model for future testing

Based on the data obtained in this study and on the literature review, the researcher has developed a new model, using both Gilligan and Kohlberg's theories as a framework. The main premise of this model is that the factors affecting unethical behavior are many and are inter-related. Testing of these varied factors and relationships may require combining several tools, as suggested in the operational definitions, or may require the development of a new instrument.

## Assumptions

The assumptions set forth for the proposed model are based on both previous research studies, as discussed previously in the literature review, and on the qualitative data obtained from this study.

1. Professional nurses make ethical decisions, using reasoning based on previous experiences and education. This reasoning utilizes a mixture of justice and caring considerations.

2. Nurses develop moral reasoning over time, as do all people, and progress to higher levels of moral development in an individual manner.

3. Moral development is dependent on cognitive and sociomoral development, although the presence of these does not always predict higher moral development.

4. Education and exposure to ethical dilemmas provide the necessary impetus to moral development.

Table 6:Theoretical and operational definitions of concepts

| Concept | Theoretical definition | Operational definition |
|---|---|---|
| Professional nurse | A person, recognized by at least one state board of nursing, as being qualified to retain RN licensure. (Hereafter referred to as "nurse".) | A person identifying themselves as "nurse" on demographic questions pertaining to occupation. |
| Ethical decisions | Action choices which are made by one individual, using ethical principles, with outcomes affecting one or more other persons (Rest, 1979). "If a nurse does not make moral choices or address the moral dilemmas in her practice, then she is not using the artistic aspects of the discipline" (Meleis, 1997, p. 98). | Action choices made by subjects (nurses), given hypothetical scenarios, as provided in the Defining Issues Test (DIT). |
| Post-secondary educational experience | Number of years of college education. "Higher education sometimes encourages reflection on, and discussion of, social and moral issues which may impact upon moral development" (Walker, 1990, p. 116). Cognitive development is theorized to be a prerequisite for moral development (Kohlberg, 1969). | Total number of years in post-high school education, to be entered on the demographic page. |
| Nursing education experience | Number of years engaged in nursing education in the student role. Nursing students are theorized to learn from repeated exposure to the ethical dilemmas of nursing education (Hoyer et al., 1991). | Number of years in nursing education, to be entered on the demographic page. |

| Concept | Theoretical definition | Operational definition |
|---|---|---|
| Level of ethical experience and preparation | Exposure to repeated role-taking experiences and ethical decision making is theorized as the impetus to moral development (Kohlberg, 1969; Kohlberg et al., 1994). | Present or previous exposure to an ethics course, entered on the demographic page. Perceived level of preparation for ethical decision making. Measured by semantic differential with a forced choice (five levels) on the demographic page. |
| Moral development | The relative importance a subject gives to principled moral considerations in making a decision about moral dilemmas (Rest, 1975; Rest, 1979). Development is theorized to progress, step-wise, in (numbered) stages. Developmental progress is highly individualized. Some nurses may progress quickly, even skipping stages. Others may maintain the same stage for many years, or even regress to a lower stage. | Perceived level of preparation for ethical decision making, as above. Stage of moral development, as measured by the Defining Issues Test (DIT). |
| Moral development equilibrium | A sense of balance, achieved at any given level of moral development. A steady state, with anchored inertia, resisting changes from outside forces. | Action choices on the DIT which fit entirely into one stage or level of moral development. |

| Concept | Theoretical definition | Operational definition |
|---|---|---|
| Moral development disequilibrium | A sense of imbalance, a sensation of belonging to two or more different stages of moral development at the same time. Resolution of disequilibrium may occur at either a higher, or a lower stage of moral development. Factors which are theorized to promote moral development are cognitive development, sociomoral development, and exposure to ethically advanced role models. Factors which are theorized to impede or discourage moral development include environmental or personal stressors, exposure to morally deviant behavior models, and an environment where value is placed on habit or convention. | Action choices, as responses on the DIT, which do not entirely fit into one stage or level of moral development. |

**Propositions and relationships of the model**

1. Equilibrium may be achieved at any given stage in moral development. See "Nurse R" in the schematic model (Figure 1) for a graphic representation. This occurs when internal and external environments are both stable, and factors which impede development are equal to, and therefore canceled out in influence by, factors which promote moral development. The nurse who is experiencing equilibrium has a feeling of comfort and stability regarding her moral and ethical decisions, and is therefore not likely to make changes.

2. Disequilibrium can occur between any stages, when factors are unequal, producing a sense of imbalance. See "Nurse Q" in the schematic model (Figure 1) for a graphic representation. Disequilibrium is necessary in order for increases in moral development to occur. It is only during periods of disequilibrium that the nurse or student questions their own moral development. It is this questioning that allows growth and development to occur. When factors which promote moral development are stronger than the factors which impede moral development, growth and learning can occur.

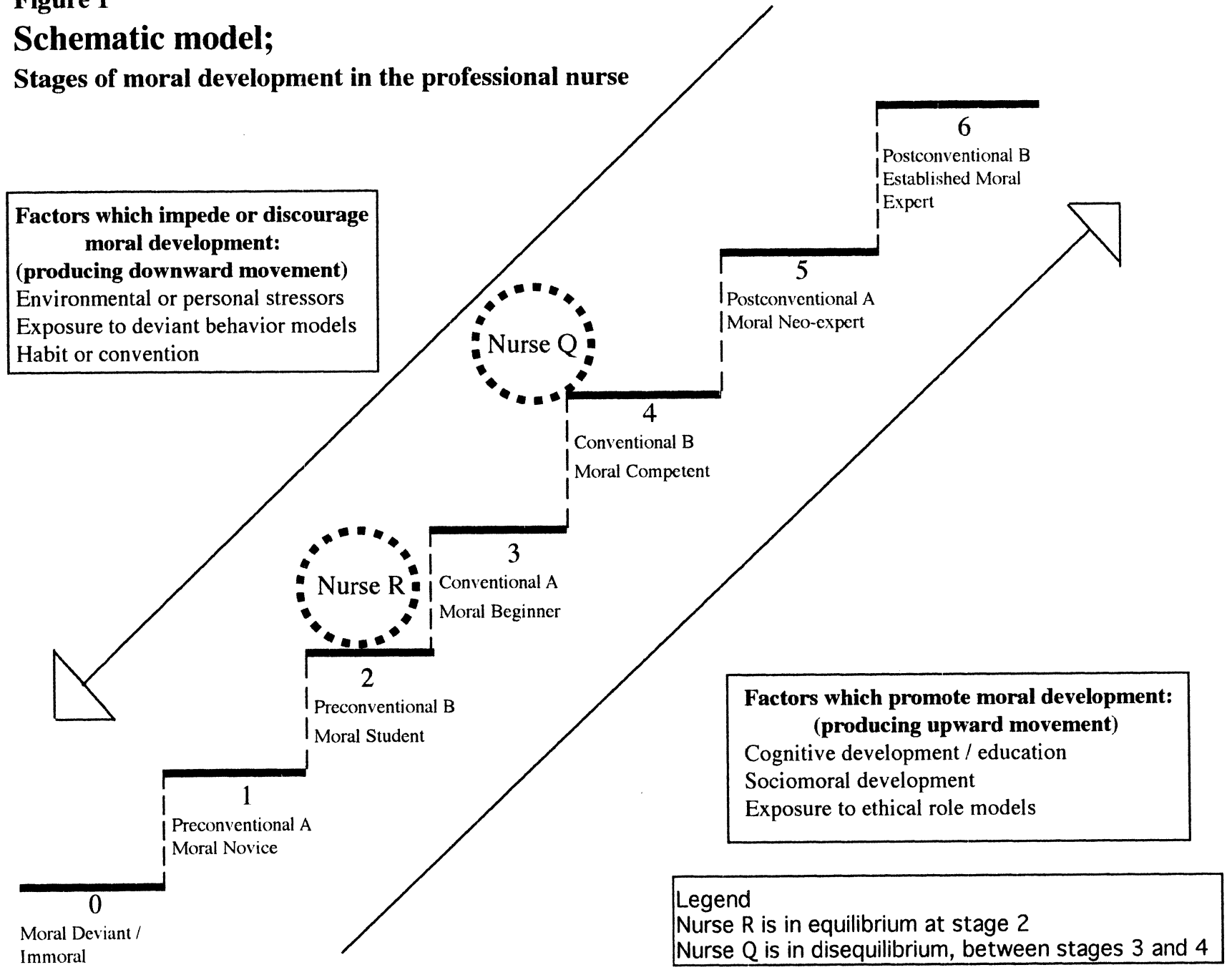
Factors which promote moral development are theorized to include: cognitive development and education, sociomoral development, and exposure to ethically advanced role models. Ethical education of nurses and nursing students should include frequent discussions of ethical and moral issues among colleagues, in order to promote the cognitive development and sociomoral awareness which are precursors of moral development. Ethically advanced role models should be available to all nurses and nursing students, through faculty and administration interaction. When these role models allow their reasons for decisions to be made public, and discussed openly by nurses and students, they are promoting ethical awareness and moral development.

Disequilibrium may also be resolved by regression to a lower stage of moral development. This can occur when factors which impede moral development are stronger than the factors which promote same. If a nurse regresses as low as stage zero, he or she becomes labelled "morally deviant", in the eyes of the nursing community, and is no longer acceptable as a nurse.

**Figure 1**

## Schematic model;

### Stages of moral development in the professional nurse



## Explanation of Figure 1

## Stages of moral development in the professional nurse

| Role of nurse re: moral development | Number and stage of moral development, with theoretical explanation |
|---|---|
| **Moral Deviant / Immoral** | 0. Not an accepted stage; not acceptable to the nursing community |
| **Moral Novice** | 1. Preconventional A;<br>Punishment v. obedience (Kohlberg)<br>Self-preservation, following norms of society (Gilligan) |
| **Moral Student** | 2. Preconventional B;<br>Self-gratification v. beginning of mutual needs awareness(Kohlberg)<br>Self-centeredness v. responsibility (Gilligan) |
| **Moral Beginner** | 3. Conventional A;<br>Interpersonal concordance, maintaining of interpersonal relationships (Kohlberg)<br>Goodness; Self-sacrifice, sharing norms of society re: goodness (Gilligan) |
| **Moral Competent** | 4. Conventional B;<br>Law and order, performing one's duty (Kohlberg)<br>Morality of care, beginning to recognize that self-care is also important (Gilligan) |
| **Moral Neo-expert** | 5. Postconventional A;<br>Societal consensus; develop and uphold laws and contracts (Kohlberg)<br>Nonviolence; care as the universal obligation (Gilligan) |
| **Established Moral Expert** | 6. Postconventional B;<br>Universal ethical principle; self-chosen principles / justice / rights (Kohlberg)<br>Logic of relationships; no harm to self or others (Gilligan) |

Factors which are theorized to impede moral development include: environmental or personal stressors, exposure to less morally developed and/or deviant behavior models, and an environment which places value on habit or convention. When a nurse is stressed beyond her usual endurance by environmental demands of work, home or school, illness or feeling of inadequacy, she may look for an "easy way" out of her problems, and may be more easily tempted to make selfish and/or immoral decisions. This becomes even more likely if role models of lower moral development are more prevalent and/or more powerful than examples of higher moral development.

Habit or convention also impedes moral development in two ways. The first is simply by promoting equilibrium, or status quo, which prevents the questioning of moral values which is necessary for learning and development to occur. The second, more dangerous way, is by ignoring ethical or immoral transgressions when they are ingrained as part of the informal work environment. Swift and impartial justice needs to be part of the work environment, along with promotion of caring values, in order for sociomoral awareness to develop (Kohlberg et al., 1994).

**Usefulness and social significance**

This model was developed with nursing education in mind, but is also potentially useful in nursing practice and research. Implications for nurse educators and administrators are included in the text, and directions for future research are implied in the operational definitions.

This model is a suggestion of ways that nurse leaders can shape the society of nursing to produce more highly developed moral agents of nursing. There is no reason this model could not be adapted for use with teachers, lawyers, doctors, or any other profession which values moral development.

Appendix A

DISCLOSURE FORM

As part of my requirements for obtaining a Master's of Science in Nursing degree from Salisbury State University, I am conducting a study of unethical behaviors among undergraduate nursing students. I am asking for your assistance in completing the questionnaire entiltled Hilbert Unethical Behaviors Survey (HUBS). You were selected to participate in this study because you are currently enrolled in at least one undergraduate nursing class at a participating school of nursing.

This questionnaire should take about 20 minutes to complete. The information is anonymous. **Do not put your name, or any other identifying marks, on the questionnaire.** I am the only person who will see these questionanaires, and they will be destroyed once the data has been analyzed. No one else will have access to these at any time.

Your cooperation and participation are strictly voluntary and your choice to participate or not to participate will in no way affect your grade in any class(es). You may leave any particular questions unanwered or may choose not to complete the questionnaire. If you choose not to participate, please complete the demographics page only. Your participation is very valuable and will assist me in exploring and describing the phenomenon of unethical behavior among undergraduate nursing students. Data will be given only as group data, and will be included in my graduate nursing thesis, for future use by other graduate nursing students and graduate nursing faculty at Salisbury State University.

Thank you for your cooperation. Sincerely, Kristal Melvin, RN.

If you have any questions or comments, please contact the graduate nursing office at Salisbury State University or **Dr. Ruth Carroll, thesis advisor,** at the following phone number: **(410) 543-6420**

Appendix B

The purpose of this questionnaire is to develop a better understanding of behaviors engaged in by nursing students in the classroom and clinical settings.

Responses are anonymous and all replies will be treated with strict confidentiality.

**Fill in the blanks** with whole numbers (0-50)

Total number of years in post-high school education: _____

Number of years in nursing education: _____

**Check** the appropriate answers

Nursing program:

1. First year of a basic (diploma or associate's degree) program _____
2. Second year of a basic program (diploma or associate) _____
3. Third year of a basic program (diploma) _____
4. Junior year of a baccalaureate program _____
5. Senior year of a baccalaureate program _____

Have you ever had an ethics course (including the current semester)?

1. yes _____
2. no _____

**Circle the number** which indicates your degree of agreement with the following statement:

I am completely prepared to handle all of the ethical dilemmas involved in nursing and nursing education.

/____1_____/____2_____/____3_____/____4_____/____5_____/

Completely Disagree — Completely Agree

Have you been made aware of any honor code, and/or system for punishment of unethical behavior, in place at this school?

1. yes _____
2. no _____

# Hilbert Unethical Behaviors Survey

Below are a series of statements concerning certain behaviors. In the column indicate how many times you have engaged in the activity described in the current academic year.

"00"= Never, "01"= Once, "02"= Twice, etc., "10"= Ten times, "99"= Ninety-nine or more times.

Non-nursing majors should answer ONLY the odd numbered questions.

| Number of times I have done this in the current academic year | | |
|---|---|---|
| ☐ | 1. | Getting exam or quiz questions from someone who had taken the exam or quiz earlier in the day (or week). |
| ☐ | 2. | Calling in sick for the clinical area or work when you were not. |
| ☐ | 3. | Copying from someone else's exam or quiz paper or receiving answers from another student during an exam or quiz. |
| ☐ | 4. | Coming to the clinical area while under the influence of drugs, including alcohol. |
| ☐ | 5. | Allowing someone to copy from an exam or quiz paper or giving answers to another student during an exam or quiz. |
| ☐ | 6. | Breaking something that belonged to the patient and not reporting it. |
| ☐ | 7. | Using notes, books, etc. during a closed-book exam or quiz. |
| ☐ | 8. | Not reporting an incident involving a patient. |
| ☐ | 9. | Taking an exam or quiz for another student. |
| ☐ | 10. | Taking hospital equipment (including scrubs) to use at home. |
| ☐ | 11. | Copying a few sentences from a reference source without quoting it in a paper. |
| ☐ | 12. | Eating food intended for or belonging to a patient. |

Number of times I have done this in the current academic year

| | | |
|---|---|---|
| ☐ | 13. | Adding a few items to a bibliography that were not used in writing the paper. |
| ☐ | 14. | Taking medication from the hospital for personal use. |
| ☐ | 15. | Turning in a paper purchased from a commercial research firm. |
| ☐ | 16. | Recording that medications, treatments or observations were done when they weren't. |
| ☐ | 17. | Turning in an assignment that was done entirely or in part by someone else (but not by a research firm). |
| ☐ | 18. | Discussing patients in public places or with non-medical personnel. |
| ☐ | 19. | Doing a homework assignment for another student. |
| ☐ | 20. | Not questioning an order when in doubt. |
| ☐ | 21. | Working with another student on an assignment when the instructor did not allow it. |
| ☐ | 22. | Failing to provide information to a patient about treatments, medications, or recommended health behaviors. |

If you answered other than 0 for item 4, please complete the following:

_____ Number of times drugs involved. Name(s) of drug(s):

_____

_____ Number of times alcohol involved. Kind and amount of alcohol:

_____

THE COLLEGE OF NEW JERSEY

April 2, 1997

Kristal C. Melvin, RN, BSN
5023 Russell Road
Woolford, MD 21677

Dear Ms. Melvin:

In response to your recent letter, you have my permission to use the HUBS in your research. The next edition of the Review of Research in Nursing Education, volume VIII, will have a chapter on academic dishonesty. This edition is in press. Attached is a list of articles which have used the tool or cited my research. I hope that this is helpful and request that you send me the results of your research.

Sincerely,

Gail Hilbert, DNSc, RN
Professor and Graduate Program Coordinator

SCHOOL OF NURSING • HILLWOOD LAKES • CN 4700 • TRENTON, NJ 08650-4700

609/771-2591 • FAX: 609/771-3366

BMDS Behavioral Measurement Database Services

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Tel (412) 687-6850 • Fax (412) 687-5213

# Health and Psychosocial Instruments (HaPI)



To: Ms. K. Melvin

From: Evelyn Perloff

Date: 7/14/97

Enclosed is a copy of the Hilbert Unethical Behaviors Survey

As I have indicated authors like to receive feedback on your study. All that is asked is to provide a purpose (brief, certainly) and, if you would, a brief report of what you found.

Enclosed also is an invoice. It covers the cost (e.g., handling, postage, and copyright fee) for this instrument.

I am sorry about the delay and wish you the best of luck with your project.

Appendix D
Addendum to HUBS tool

Classroom Unethical Behaviors

Please describe the details and reason(s) pertaining to participation in any Classroom unethical behaviors:

Clinical Unethical Behaviors

Please describe the details and reason(s) pertaining to participation in Clinical unethical behaviors:

Thank you for your participation.

JUDITH S. CALDWELL, CHAIR
DELAWARE TECHNICAL COMMUNITY COLLEGE, NURSING DEPARTMENT
JACK F. OWENS CAMPUS
P.O. BOX 610
ROUTE 18
GEORGETOWN, DELAWARE 19947

October 29, 1997

Dear Ms. Caldwell:

I am currently a graduate student at Salisbury State University, enrolled in the Family Nurse Practitioner track, and have begun work on my thesis. I have proposed a study of cheating and dishonesty among nursing students, and would appreciate the assistance of yourself and the faculty of Del-Tech College School of Nursing. My research topic and proposed methods are explained more fully in the enclosed abstract.

I would like permission to gather data from your students during class hours. As you will see in the enclosed disclosure statement, students' participation is strictly voluntary, and the questionnaires are completely confidential. Results of this research will be available to the public, as group data only, after completion.

Signature below constitutes written permission. Please return the original letter in the enclosed SASE. A copy of this letter will be forwarded to the Human Subjects Committee at SSU for approval.

Thank you,

Kristal Melvin

Kristal C. Melvin, RN

Judith S Caldwell 11/5/97

Signature date

KRISTAL C. MELVIN, R.N., B.S.N.
5023 RUSSELL RD. • WOOLFORD, MD. 21677 • PHONE # (410) 228-0276

DENISE MARSHALL
WOR-WIC COMMUNITY COLLEGE, NURSING DEPARTMENT
CAMBRIDGE, MD. 21613

October 27, 1997

Dear Ms. Marshall:

I am currently a graduate student at Salisbury State University, enrolled in the Family Nurse Practitioner track, and have begun work on my thesis. I have proposed a study of cheating and dishonesty among nursing students, and would appreciate the assistance of yourself and the faculty of Wor-Wic Community College School of Nursing. My research topic and proposed methods are explained more fully in the enclosed abstract.

I would like permission to gather data from your students during class hours. As you will see in the enclosed disclosure statement, students' participation is strictly voluntary, and the questionnaires are completely confidential. Results of this research will be available to the public, as group data only, after completion.

Signature below constitutes written permission. Please return the original letter in the enclosed SASE. A copy of this letter will be forwarded to the Human Subjects Committee at SSU for approval.

Thank you,

Kristal Melvin

Kristal C. Melvin, RN

Denise Marshall 11/5/97

Signature date

KRISTAL C. MELVIN, R.N., B.S.N.
5023 RUSSELL RD. • WOOLFORD, MD. 21677 • PHONE # (410) 228-0276

LISA SELDOMRIDGE, DIRECTOR
SALISBURY STATE UNIVERSITY, NURSING DEPARTMENT
SALISBURY, MD.

October 29, 1997

Dear Dr. Seldomridge:

I am currently a graduate student at Salisbury State University, enrolled in the Family Nurse Practitioner track, and have begun work on my thesis. I have proposed a study of cheating and dishonesty among nursing students, and would appreciate the assistance of yourself and the faculty of Salisbury State University School of Nursing. My research topic and proposed methods are explained more fully in the enclosed abstract.

I would like permission to gather data from your students during class hours. As you will see in the enclosed disclosure statement, students' participation is strictly voluntary, and the questionnaires are completely confidential. Results of this research will be available to the public, as group data only, after completion.

Signature below constitutes written permission. Please return the original letter in the enclosed SASE. A copy of this letter will be forwarded to the Human Subjects Committee at SSU for approval.

Thank you,

Kristal C. Melvin

Kristal C. Melvin, RN

Lisa A Seldomridge 10/31/97

Signature date

KRISTAL C. MELVIN, R.N., B.S.N.
5023 RUSSELL RD. • WOOLFORD, MD. 21677 • PHONE # (410) 228-0276

References

Alexander, G. (1992). The incidence and implications of academic fraud among nursing students. Nursing World Journal, 18, 14-15.

Allmark, P. (1995). Uncertainties in the teaching of ethics to students of nursing. Journal of Advanced Nursing, 22, 374-378.

American Association of Colleges of Nursing (1986). Essentials of College and University Education for Professional Nursing. Washington, DC.: AACN.

American Nurses Association (1985). Code for nurses, with interpretive statements. Kansas City, MO.: ANA.

Aroskar, M. (1991). Caring - another side. Journal of Professional Nursing, 7(1), 3.

Bailey, P. (1990). Cheating among nursing students. Nurse Educator, 15(3), 32-35.

Baird, J. (1980). Current trends in college cheating. Psychology in the Schools, 17, 512-522.

Barnett, D., & Dalton, J. (1981). Why college students cheat. Journal of College Student Personnel, 22, 545-551.

Blatt, M., & Kohlberg, L. (1994). The effects of classroom moral discussion upon children's level of moral judgement. In B. Puka (Ed.), Moral development; A compendium, volume 2; Fundamental research in moral development (pp. 1-33). New York: Garland Publishing, Inc..

Booth, D., & Hoyer, P. (1992). Cheating: faculty responsibility when integrity fails . Nursing Outlook, 40(2), 86-93.

Bradshaw, M., & Lowenstein, A. (1990). Perspectives on academic dishonesty. Nurse Educator, 15(5), 10-15.

Brink, P., & Wood, M. (1978). Basic steps in planning nursing research; From question to proposal. Belmont, California: Duxbury Press.

Bowers, W. (1964). Student dishonesty and its control in college. New York: Bureau of Applied

Social Research, Columbia University.

Bushway, A., & Nash, W. (1977). School cheating behavior. Review of Educational Research, 47(1), 623-32.

Campbell, W. (1933). Measurement in determining the personality and behavior of the college cribber. Education, 54, 403-408.

Canning, R. (1956). Does an honor system reduce classroom cheating? An experimental answer. Journal of Experimental Education, 24, 291-296.

Carmack, B. (1984). Exploring nursing educator's experience with student plagiarism. Nurse Educator, 9(2), 29-33.

Cassells, J., & Redman, B. (1989). Preparing students to be moral agents in clinical nursing practice; Report of a National study. Nursing Clinics of North America, 24(2), 463-473.

Cassidy, V. (1996). Moral competency. In Annual Review of Nursing Research (Vol. 14) (pp. 181-204). New York: Springer.

Cassidy, V., & Oddi, L. (1988). Professional autonomy and ethical decision-making among graduate and undergraduate nursing majors. Journal of Nursing Education, 27(9), 405-410.

Cassidy, V., & Oddi, L. (1991). Professional autonomy and ethical decision-making among graduate and undergraduate nursing majors: A replication. Journal of Nursing Education, 30(4), 149-151.

Clay, M.,& Povey, R. (1983). Moral reasoning and the student nurse. Journal of Advanced Nursing, 8, 297-302.

Daniel, L., Adams, B., & Smith, N. (1994). Academic misconduct among nursing students: a multivariate investigation. Journal of Professional Nursing, 10, 278-288.

Daniel, L., Blount, K., & Ferrell, C. (1991). Academic misconduct among teacher education students: A descriptive-correlational study. Research in Higher Education, 32,703-724.

Davis, M., Johnston, S., DiMicco, M., Findlay, M., & Taylor, J. (1996). The case for a student

honor code and beyond. Journal of Professional Nursing, 12(1), 24-30.

Diekhoff, G., LaBeff, E., Clark, R., Williams, L., Francis, B., & Haines, V. (1996). College cheating: Ten years later. Research in Higher Education, 37(4), 487-502.

Dierckx de Casterle', B., Janssen, P., & Grypdonck, M. (1996). The relationship between education and ethical behavior of nursing students. Western Journal of Nursing Research, 18, 330-350.

Duckett, L., Rowan-Boyer, M., Ryden, M., Crisham, P., Savik, K., & Rest, J. (1992). Challenging misperceptions about nurses' moral reasoning. Nursing Research, 41(6), 324-331.

Eisenberger, R., & Shank, D. (1985). Personal work ethic and effort training affect cheating. Journal of Personality and Social Psychology, 49, 520-528.

Fass, R. (1986). By honor bound: Encouraging academic dishonesty. Educational Record, 67, 32-36.

Felton, G., & Parsons, M. (1987). The impact of nursing education on ethical/moral decision making. Journal of Nursing Education, 26(1), 7-11.

Ferrell, C. (1992a). A frame of reference for understanding behaviors related to the academic misconduct of undergraduate teacher education students. (Doctoral dissertation, University of Southern Mississippi), in Ferrell, 1992b.

Ferrell, C. (1992b). Assessing teacher education students' propensity toward academic misconduct. Paper presented at the Annual Meeting of the Mid-South Educational Research Association, Knoxville, TN.

Ferrell, C., & Daniel, L. (1995). A frame of reference for understanding behaviors related to the academic misconduct of undergraduate teacher education students. Research in Higher Education, 36, 345-375.

Fossbinder, D. (1991). Cheating and plagiarism. Nurse Educator, 16(6), 5.

Gardner, W., Roper, J., Gonzalez, C., & Simpson, R. (1988). Analysis of cheating on academic

assignments. The Psychological Record, 38, 543-555.

Genereux, R., & McLeod, B. (1995). Circumstances surrounding cheating: A questionnaire study of college students. Research in Higher Education, 36, 687-704.

Gilligan, C. (1977). In a different voice: Women's conceptions of self and of morality. Harvard Educational Review, 47(4), 481-517.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge: Harvard University Press.

Gilligan, C., & Attanucci, J. (1988). Two moral orientations: Gender differences and similarities. Merrill-Palmer Quarterly, 34(3), 223-237.

Haines, V., Diekhoff, G., LaBeff, E., & Clark, R. (1986). College cheating: Immaturity, lack of commitment, and the neutralizing attitude. Research in Higher Education, 25, 342-354.

Harnest, P. (1986). The perceptions of student academic honesty in a school of nursing (cheating) (Doctoral dissertation, North Texas State University). Dissertation Abstracts International, 47, 2825A.

Harp, J., & Taietz, P. (1966). Academic integrity and social structure: A study of cheating among college students. Social Problems, 13, 365-373.

Hetherington, E., & Feldman, S. (1964). College cheating as a function of subject and situational variables. Journal of Educational Psychology, 55, 212-218.

Hilbert, G. (1985). Involvement of nursing students in unethical classroom and clinical behaviors. Journal of Professional Nursing, 1, 230-234.

Hilbert, G. (1987). Academic fraud: Prevalence, practices and reasons. Journal of Professional Nursing, 3, 39-45.

Hilbert, G. (1988). Moral development and unethical behavior among nursing students. Journal of Professional Nursing, 4, 163-167.

Hilbert, G. (1996). The Hilbert Unethical Behavior Survey. [On-line]. [CD-ROM]. Abstract from: CDP file: HaPI-CD. HaPI item: 995.

Hoyer, P., Booth, D., & Richardson, C. (1991). Clinical cheating and moral development. Nursing Outlook, 39, 170-173.

Jeffreys, M., & Stier, L. (1991). Student academic dishonesty: Issues for nurse educators. Dean's Notes, 12, 1-3.

Jeffreys, M., & Stiers, L. (1995). Speaking against student academic dishonesty: a communication model for nurse educators. Journal of Nursing Education, 34, 297-304.

Jendrek, M. (1992). Students' reactions to academic dishonesty. Journal of College Student Development, 33, 260-273.

Johnson, C., & Gormly, J. (1972). Academic cheating: The contribution of sex, personality, and situational variables. Developmental Psychology, 6, 320-325.

Karlins, M., Michaels, C., & Podlogar, S. (1988). An empirical investigation of actual cheating in a large sample of undergraduates. Research in Higher Education, 29(4), 359-364.

Kohlberg, L. (1969). Kohlberg's original study of moral development. In B. Puka (Ed.) (1994), Moral development; A compendium, volume 3 (pp. 1-353). New York: Garland Publishers, Inc..

Kohlberg, L., Levine, C., & Hewer, A. (1994). Moral stages: A current formulation and a response to critics. In B. Puka (Ed.), Moral development;A compendium, volume 5; New research in moral development (pp. 126-189). New York: Garland Publishing, Inc..

Kopala, B. (1994). Conflicts in nurse educators' role obligations. Journal of Professional Nursing, 10(4), 236-243.

Lamont, L. (1979). Campus shock: A firsthand report on college life today. New York: E. P. Dutton.

Lipson, A., & McGavern, N. (1993). Undergraduate academic dishonesty at MIT: Results of a study of attitudes and behavior of undergraduates, faculty, and graduate teaching assistants. Boston: Massachusetts Institute of Technology.

Macrina, F., & Munro, C. (1995). The case study approach to teaching scientific integrity in

nursing and the biomedical sciences. Journal of Professional Nursing, 11(1), 40-44.

Maramark, S., & Maline, M. (1993). Academic dishonesty among college students; Issues in education. Washington, DC: Office of Educational Research and Improvement.

May, K., & Loyd, B. (1993). Academic dishonesty: The honor system and students' attitudes. Journal of College Student Development, 34, 125-129.

McCabe, D., & Trevino, L. (1997). Individual and contextual influences on academic dishonesty: A multi-campus investigation. Research in Higher Education, 38(3), 379-396.

Michaels, J., & Miethe, T. (1989). Applying theories of deviance to academic cheating. Social Science Quarterly, 70, 870-884.

Meleis, A. (1997). Theoretical nursing: Development and progress (3rd ed.). Philadelphia: Lippincott.

Munhall, J.. (1980). Moral reasoning levels of nursing students. Image: Journal of Nursing Scholarship, 12(3), 57-61.

Mustapha, S., & Seybert, J. (1989). Moral reasoning in college students: Implications for nursing education. Journal of Nursing Education, 28(3), 107-111.

Newhouse, R. (1982). Alienation and cheating behavior in the school environment. Psychology in the Schools, 19, 234-237.

Nokes, K. (1989). Rethinking moral reasoning theory. Image: Journal of Nursing Scholarship, 21(3), 172-75.

Nolan, P., & Smith, J. (1995). Ethical awareness among first year medical, dental and nursing students. International Journal of Nursing Studies, 32, 506-517.

Parr, F. (1936). The problem of student honesty. Journal of Higher Education, 7, 318-326.

Partello, P. (1993). First-year students and cheating: A study at Keene State College. Research Strategies, 2, 174-179.

Pemberton, C. (1983). Student and faculty surveys on academic honesty at the University of Delaware. (Institutional research study 83-32.) Newark, DE: University of Delaware.

Perry, A., Kane, K., Bernesser, K., & Spicker, P. (1990). Type A behavior, competitive, achievement-striving, and cheating among college students. Psychological Reports, 66, 459-465.

Peter, E., & Gallop, R. (1994). The ethic of care: A comparison of nursing and medical students. Image: Journal of Nursing Scholarship, 26(1), 47-51.

Polit, D., & Hungler, B. (1995). Nursing research: Principles and methods (5th ed.). Philadelphia: J. B. Lippincott Co..

Quinn, C. (1990). A conceptual approach to the identification of essential ethics content for the undergraduate nursing curriculum. Journal of Advanced Nursing, 15, 726-731.

Rest, J. (1975). Longitudinal study of the Defining Issues Test of moral judgement: A strategy for analyzing developmental change. Developmental Psychology, 11,738-748.

Rest, J. (1979). Development in judging moral issues. Minneapolis: University of Minnesota Press.

Rozance, C. (1991). Cheating in medical schools: Implications for students and patients. Journal of the American Medical Association, 266(17), 2453, 2456.

Scheers, N., & Dayton, C. (1987). Improved estimation of academic cheating behavior using the randomized response technique. Research in Higher Education, 26, 61-69.

Sheer, B. (1989). The relationships among socialization, empathy, autonomy, and unethical student behaviors in baccalaureate nursing students. Dissertation Abstracts International, 51, 147B.

Sierles, F., Hendrickx, I., & Circle, S. (1980). Cheating in medical school. Journal of Medical Education, 55, 124-125.

Simpson, D., Yindra, M., Towne, J., & Rosenfeld, P. (1989). Medical students' perceptions of cheating. Academic Medicine, 64, 221-2.

Singhal, A. (1982). Factors in students' dishonesty. Psychological Reports, 51, 775-780.

Stern, E., & Havlicek, L. (1986). Academic misconduct: Results of faculty and undergraduate

student surveys. Journal of Allied Health, 15, 129-142.

Stimmel, B., & Yens, D. (1982). Cheating by medical students on examinations. American Journal of Medicine, 73, 160-164.

Sykes, G., & Matza, D. (1957). Techniques of neutralization: A theory of delinquency. American Sociological Review, 22, 664-670.

Tanner, C. (1990). Caring as a value in nursing education. Nursing Outlook, 38(2), 70-72.

Thompson, D. (1991). Ethical case analysis using a hospital bill. Nurse Educator, 16(4), 20-23.

Tom, G., & Borin, J. (1988). Cheating in academe. Journal of Education for Business, 1, 153-157.

Walker, L. (1984). Sex differences in the development of moral reasoning: A critical review. Child Development, 55, 677-691.

Walker, L. (1990). Cognitive processes in moral development. In G. Sapp (Ed.), Handbook of moral development (pp. 109-145). Birmingham, Alabama: Religious Education Press.

Walker, L., de Vries, B., & Trevethan, S. (1987). Moral stages and moral orientations in real-life and hypothetical dilemmas. Child Development, 58, 842-858.

Waltz, C., Strickland, O., & Lenz, E. (1984). Measurement in nursing research. Philadelphia: F. A. Davis Company.

Ward, D., & Beck, W. (1990). Gender and dishonesty. The Journal of Social Psychology, 130, 333-39.

Woolfolk, A. (1995). Educational Psychology (6th ed.). Boston: Allyn and Bacon.

# Kristal C. Melvin, RN, BSN

**5023 Russell Road**
**Woolford, MD. 21677**
**(410) 228-0276**


**EDUCATION:**

M.S.N. Salisbury State University — 1/95-5/98
Family Nurse Practitioner Certification track

B.S.N. Western Carolina University — May 1991, Summa
Major in Nursing, with concentration in
Health Services Management and Supervision

A.S.N. Manatee Junior College — May 1981, with Honors

Attended Guilford College, Greensboro, N.C. — 1975-77
Psychology major

**WORK EXPERIENCE:**

Primary care provider, clinical experience totalling more than 600 hours, precepted through Fassett-Maggee Community Health Center, Cambridge, MD. and Rose Hill Pediatrics, Cambridge, MD. — 8/96-pres

Adjunct Faculty, Clinical Instructor; Med-surg., Pediatrics — 8/95-pres
Wor-Wic Community College, Cambridge, MD

Staff Nurse, 13 bed Intensive Care Unit — 1/98-pres
Dorchester General Hospital, Cambridge, MD

Staff Nurse, Relief charge nurse — 9/941/98
36 bed Medical-Surgical unit (2 East)
Dorchester General Hospital, Cambridge, MD

Staff Nurse, 40 bed Medical-Surgical unit — 6/92-7/93
Member and facilitator, Staff Education Council
Member, Infection Control Committee
Member of a TQM team re: lab reporting times
C.J. Harris Community Hospital, Sylva, N.C.

Staff Nurse, 43 bed Orthopedic unit — 1/92-4/92
St. Ann's Hospital, Westerville, Ohio 43081

Charge Nurse, 18 bed Medical-Surgical unit. — 11/85-7/89
St. Lukes Hospital, Columbus, N.C.

Relief Team Leader, 42 bed Medical-Surgical unit, — 9/86-8/88
and Relief Staff Nurse, Emergency room
Park Ridge Hospital, Fletcher, N.C.

Team Leader, 40 bed Surgical unit. — 8/83-11/85
Pardee Memorial Hosp., Hendersonville, N.C.

Primary Nurse, Surgical unit — 5/81-8/83
Staff Nurse, Orthopedic unit
L. W. Blake Hospital, Bradenton, Fl.

**LICENSURE:**

Certified Registered Nurse Practitioner (pending); Maryland
Registered Nurse; Maryland

**ACCOMPLISHMENTS & INTERESTS:**

Active member, Sigma Theta Tau International, inducted Nov.,1990
Advanced Cardiac Life Support Certification, through May 2000
Career interests: Health education, Child and maternal health, Epidemiology
Personal interests: Sailing, gardening, stained glass

**RESEARCH AND PUBLICATIONS:**

Thesis topic: Academic and Clinical Dishonesty in Undergraduate Nursing Students, May, 1998
Previous research: Cancer Distribution Study, Jackson County, N.C., 1990
Peer Teaching and the Adult Learner, 1995
Family Analysis; A Qualitative Study, 1996
Stress and the College Student, 1997