Journal of Community and Public Health Nursing

Malloy et al., J Comm Pub Health Nurs 2017, 3:2
DOI: 10.4172/2471-9846.1000165

Research Article OMICS International

An International Study of Nurses' Ethical Ideology and Religiosity

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Received date: February 23, 2017; **Accepted date:** March 15, 2017; **Published date:** March 22, 2017

Abstract

To suggest that the nursing landscape is complex is a profound understatement. As nurses care for patients in a continuum of health, they are also confronted with the personal demands of their own value systems and religious belief systems in tandem with values and culture of the hospital. In an effort to shed some light on this complexity, this international study of nurses from four nations explored the relationship between religiosity and ethical ideology. The findings indicate that while there was no significant association between religiosity and ideology, nurses' religiosity, ethical idealism, and ethical relativism differ as a function of country/culture. Future research can investigate whether these differences manifest themselves in behaviour.

Keywords: Nurses; Ethical ideology; Religiosity

Introduction

In the provision of modern healthcare, nurses, along with their multidisciplinary co-workers, face complex ethical challenges to which institutional rules and professional codes of conduct cannot provide immediate or simple answers [1,2]. The variety of such challenges are immediately apparent with even the most superficial engagement with the canon of nursing and medical ethics research, and as Malloy et al. [3] have demonstrated, in many such situations, where neither training nor policy is clear, an individual's personal ethical and value orientation can become at least an influence and even the basis for decisions.

The nurse occupies a unique position within the healthcare team. Although not making final decisions about what medical interventions ought or ought not to be made in any given circumstance, the nurse is responsible for the delivery of prescribed medical care. Therefore ethical beliefs matter because they impact on the patient in at least two ways. First, an important concept within nursing is the role of the nurse as patient advocate [4,5]. Advocacy implies having an influence on the patient's unfolding history through the ongoing dialogue with patients, their families, and healthcare providers in general. A nurse's ethical viewpoint may impact upon the kind of support the patient will receive. For example, there is substantial evidence that demonstrates that nurses often disagree with invasive medical treatments in situations where survival is unlikely [6-8]. Second, the nurse also has to deliver care. If the individual's ethical ideology leads to conflict/disagreement about prescribed medical care or if the nurse believes that other constraints such as availability of resources or the organizational culture conflict with personal values, then he or she will suffer consequences that have been described by researchers, such as burn out [9,10] and moral distress [1,11,12], all of which can reduce the ability to remain with the patient and to function effectively.

It is therefore clear that a nurse's ethical framework matters to the delivery of patient care. There are a number of factors that will influence the ethical viewpoint of the nurse, such as, the close proximity to the patient in comparison to other health care workers [13]. However, it is less well understood as to what extent other factors and in the case of this paper, specifically religion and ethical ideology, might influence how ethical behaviour is manifested.

It has been found that religious belief may influence interpersonal conduct, including ethical behaviour [14-16] but it has been argued that there has been little interest or understanding of how a nurse's religion impacts on practice [17]. Some authors have answered this criticism by seeking to explain how a religious belief might inform nursing practice. For example Cusveller [18] sought to explain how the beliefs and values of Calvinism would inform a Calvinist nurse's practice and Atkinson [19] found in her empirical study on Muslim nurses in Kuwait, that their religion could not be separated from the nursing practice that they delivered. Davis et al. [20] found that nurses whose ethical beliefs were mainly formed by religious beliefs, tended to experience higher degrees of moral distress in their delivery of nursing care.

O'Fallon and Butterfield [21] in their review of ethical decision making found that ethcal orientation, and, in particular the level of idealism in relation to relativism, has a direct impact on the ability to make effective ethical decisions. Those who are idealistic in their moral orientation insist that they must always avoid harming others. On the other hand, non-idealists accept that some degree of harm may be necessary to produce the greatest good. Relativists argue that there are always exceptions to moral rules in contrast to non-relativists who believe that one must always avoid harming others, whereas nonidealists assume that harm will sometimes be necessary to produce good... relativists assume that exceptionless moral principles do not exist, whereas nonrelativists assume that such principles as "thou shalt not lie" provide useful guidelines for action (pp: 244).

Malloy et al. [22] subsequently sought to investigate the part that religious belief played in the development of idealistic and relativistic reasoning in doctors' professional ethical values. They found that religiosity (i.e., the relative intensity of religious belief and practice) had a positive relationship with ethical idealism. There was a negative relationship between religiosity and ethical relativism. These findings suggest that the interaction of religion and ethical ideology may have

an impact on decision-making behaviour. For example, a nurse who is not religious (i.e., low in religiosity) and ethically relativist (i.e., low in idealism) will approach a decision with a much broader range of possible processes and outcomes than will the nurse high in religiosity and high in idealism (i.e., there are universal principles unaffected by culture). This may be most acute in cases of DNR (Do Not Resuscitate) orders or physician assisted dying. To date the relationship of idealism and relativism to the religion that a nurse might practice has not been investigated. Nor has this been investigated across different countries. Thus in order to further our understanding of the impact of individual value systems and their impact on decision behaviour, the purpose of this paper is to shed light on the relationship between religiosity and ethical ideology in an international nursing context.

Ethical Ideology

In order to measure the ethical orientation of nurses in this study, the Ethical Position Questionnaire (EPQ) was selected [23]. The EPQ has been used in a variety of contexts, including nursing, psychology, and medicine [24,25]. Two ethical constructs form the basis for the EPQ. The first is termed idealism and refers to the belief that universal goodness is achievable and positive outcomes are possible. Relativism describes the belief that problems and their solutions are unique to cultural contexts and no one set of absolute beliefs, rules, or global behaviours are sacrosanct.

These two constructs are juxtaposed in a 2 × 2 matrix with four cells emerging based upon a range from low to high (i.e., high vs. low idealism and high vs. low relativism) (Table 1). These four cells represent ethical ideologies or the ethical lens through which an individual views the world and the manner in which they frame ethical dilemmas within it.

		Relativism	
		Low	**High**
Idealism	**High**	Absolutism – rejects context in favour of universal norms	Situationism – rejects moral absolutes for greater good
	Low	Exceptionism – conformity to rules desirable with some exceptions	Subjectivism – rejects moral absolutes recognising harm may occur

Table 1: Ethical Ideology.

Forsyth [23] termed the cells as situationalism, absolutism, subjectivism, and exceptionism. Situationism (i.e., high idealism and high relativism) rejects moral absolutes and contends that, by being contextual, the greater good can be obtained (e.g., consequentialism or teleology). Absolutism (i.e., high idealism and low relativism) rejects context in favour of universal moral rules (i.e., non-consequentialism or deontology) and by doing so believes that good consequences can be realised. The cell that rejects moral absolutes in favour of contextualism and proposes that some harm may occur as we make moral choices is termed subjectivism (i.e., low idealism and high relativism). While this cell has been described by Forsyth [23,26,27] as egoistic and sceptical, it may also appeal to an existential perspective that rejects absolutism and embraces the fundamental subjectivity of decision-making [28,29]. Finally, exceptionism (i.e., low idealism and low relativism) views conformity to moral rules as desirable yet regards exceptions to these rules as permissible. From this theoretical basis, Forsyth [23] developed a twenty-item instrument to measure these four dimensions. The Ethics Position Questionnaire (EPQ) consists of ten questions pertaining to idealism and ten questions pertaining to relativism. In our study, we posit that there may be differences in ethical ideology due to cultural variance [30]. For example, in a meta-analysis by Forsyth et al. [31] it was found that individuals from 'Eastern" countries (e.g. Japan) tended to be more situationist and subjectivist; individuals from the Middle East (e.g. Egypt) were more absolutist; and individuals from Western countries (e.g. Canada) were more exceptionist.

Religiosity

Religiosity refers to the relative intensity of an individual's religious belief. It manifests itself according to Glock [32] in one or more of four dimensions. Ritualistic religiosity refers to the extent to which an individual participates in ritual such as prayer, diet, and dress codes. Experimental religiosity speaks to the emotional experience one receives through religion. Ideological religiosity describes adherence to the religion's institution – its belief system. Finally, consequential religiosity is the extent to which one's religion actually plays a role in decision-making behaviour. This later dimension has been the focus of a variety of studies that link religiosity with ethical conduct [14,16].

The literature indicates that there is reason to assume that relationships exist between ethical ideology and religiosity among nurses [17,33]. Further there is reason to assume that some variation will occur as a function of culture. Forsyth et al. [31] and Hofstede [30] suggested that approaches to decision-making would vary from culture to culture as a function of variance in belief, tolerance for ambiguity, masculinity, collectivism, etc. Further, the more intense one's religious convictions are, the more one's ethical ideology is embedded. Based upon the preceding review of the literature, the following hypotheses have emerged:

1) There will be differences in religiosity between participating countries. Specifically, based upon previous research [30,31], we predict that nurses from Western countries (Ireland) will differ in their religiosity from Eastern countries (Japan, China, Thailand and India);

2) There will be variation in ethical ideology between participating countries.

Similarly, based upon previous research [30,31], we predict that nurses from Western countries (Ireland) will differ in their ethical ideology from Eastern countries (Japan, China, Thailand and India);

3) There will be an inverse relationship between relativism and religiosity; and

4) There will be a positive relationship between idealism and religiosity.

Methods

Participants and procedures

This paper examines variations in general ethical orientation and religiosity of nurses in, China, Japan, Korea and Ireland. The rationale for selecting these countries is threefold. First, each of these countries has a dominant religious/philosophical orientation (e.g. China/Confucianism; Japan/Buddhism and Shinto; Ireland/Catholicism; and Korea, Buddhist and Christian). Second, countries were selected based upon the variability demonstrated on the cultural dimensions as defined and indexed by Hofstede [30]. Third, we selected countries based upon the availability of interested scholars willing to actively participate in the research and data collection in their home country. Nurses in this study were participating in a larger investigation exploring the cross-cultural influences on ethical decision-making. Ethics approval was received from the lead author's Research Ethics Board. Nurses in China, Japan, and Korea were recruited through personal contacts of the researchers at university and local hospitals; nurses from Ireland were contacted via the national register held by the Irish Nursing Board and questionnaires were sent to a random sample and returned to Dr. Fahey-McCarthy. A total of 1247 surveys were returned. Japan yielded the highest response (703 returned) followed by Korea (270 returned), China (197 returned) and Ireland (77 returned).

Participants in this study had an average age of 35.3 years (SD=9.9) and had been practicing nursing for 12.1 years (SD=9.5). Our sample was primarily female (94.8%). In terms of religious affiliation, nearly all Irish nurses identified with a particular religious affiliation (76.6% being Catholic). In Korea, approximately half declared a religious affiliation (49.6%) the most common of which was a Christian denomination (84.3% of those self-described as religious. In China, 69.0% of nurses did not identify any religious affiliation. Of those who did, 37.7% were Buddhist and 39.3% were Confucian; the remaining 22% identified as Christian and Taoist. In Japan, 85.8% of respondents did not declare a religious affiliation and 11.9% declared as Atheists.

Translation

When conducting cross-cultural research it is critical that each the language used across cultures is as equivalent as possible. McDonald [34] states: "variations in language exert a considerable concern for comparative research designs as substantive difference between countries become confounded with measurement incongruences" (p. 94). To minimize the impact of language differences the questionnaire underwent a translation and back-translation process [35]. Specifically, the questionnaire package was originally compiled in Canada (English). For Ireland the questionnaire was delivered in English. For Japan, China and Korea, the questionnaire was translated in those countries and then back-translated into English by Canadian language experts. The back-translations were reviewed by members of the research team to ensure accuracy. While no translation is entirely error free, this method minimizes potential threats to the study's validity.

Measures

Ethics position questionnaire

Ethical ideology was assessed with the Ethics Position Questionnaire (EPQ) [23]. The EPQ consists of 20 Likert-style items of which 10 pertain to idealism and 10 pertain to relativism. The mean score of their responses to the idealism items and the mean score of their responses to the relativism items yield two EPQ scores. The EPQ has been shown to be reliable, valid and not reflective of social desirability bias [23,36,37]. For the current study, the overall internal reliabilities for the full sample using Cronbach's alpha for the scales were 0.87 for idealism and 0.81 for relativism.

Religiosity

Rohrobaugh and Jessor's [38] Religiosity Measure was used to assess nurses' perceptions of their intrinsic religiosity. Working from Glock's [32] four dimensions of religiosity, the instrument assesses the religious orientation of the individual without identifying that orientation with an external religious network or social structure [39]. In this study, the total score was utilized and the internal consistency using Cronbach's alpha was 0.85.

Results

To determine whether differences existed on ethical idealism, ethical relativism and religiosity, three separate two-way Analyses of Variance (ANOVA) were conducted with country serving as the fixed factor.

	Ireland M (SD)	Japan M (SD)	Korea M (SD)	China M (SD)	Tamhane	p<
Religiosity	21.33 (7.31)	14.90 (4.91)	15.87 (7.44)	13.41 (5.59)	Ireland>Japan	0.001
	N=77	N=681	N=265	N=178	Ireland>China	0.001
					Ireland>Korea	0.001
					Korea>China	0.001
Ethical Idealism	7.48 (1.10)	7.46 (1.00)	6.89 (1.02)	7.28 (1.17)	Ireland>Korea	0.001
					Japan>Korea	0.001
					China>Korea	0.001

Ethical Relativism	5.48 (1.69)	6.33 (0.92)	5.76 (1.11)	6.48 (1.20)	Japan>Korea	0.001
					Japan>Ireland	0.001
					China >Korea	0.001
					China>Ireland	0.001

Table 2: Descriptive statistics and statistically significant comparisons between countries.

Experience as measured by the number of years in nursing practice was associated with idealism ($r=0.27$, $p<0.001$) and religiosity ($r=0.15$, $p<0.001$) and was considered for inclusion as a covariate. However conducting the analyses both with and without covarying years of experience did not substantively alter the results. As such, for ease of presentation, the reported findings do not include nursing experience a covariate. For each of the three ANOVA's Levine's test for equality of error variance yielded a significant result, thus individual post hoc comparisons using Tamhanes T2 were carried out for each analysis. For each ANOVA, six pairwise comparisons between countries were made. As such, to protect against Type 1 errors we have adopted a more conservative alpha (i.e., 0.05/6) of $p<0.008$ as our threshold for statistical significance (Table 2).

Religiosity. A significant main effect was identified for country, $F(3,1197)=35.67$, $p<0.001$, $\eta p^2=0.08$ and thus the first hypothesis is supported. On this measure, nurses from Ireland reported significantly higher rates of religiosity than nurses from Japan, Korea and China. Nurses from Japan and Korea also scored higher than nurses from China.

Prior to comparing overall mean differences, we examined the portion of nurses within each country that fit the Forsythe categories of ethical orientation. Table 3 presents these results. While all countries showed high proportions of absolutists and situationists, some differences between countries were observed within the two categories of ethical orientation. Over half of Irish nurses surveys were classified as absolutists compared to less than a third who were classified as situationists. In contrast, the reverse patterns were found for Japanese and Chinese nurses; over half were classified as situationists. Among all four countries, the fewest nurses were classified as exceptionists.

Country	Exceptionists	Absolutists	Subjectivists	Situationists
Ireland	3.8	51.9	6.5	31.2
Japan	3.8	29.4	4.7	55.2
Korea	2.2	40.7	12.6	36.3
China	5.1	23.4	11.2	53.8

Table 3: Percentage of nurses classified according to ethics position by country.

Ethical Idealism. A significant main effect was identified for country, $F(3,1227)=19.85$, $p<0.001$, $\eta p^2=0.05$. On this measure, nurses from Ireland, Japan and China reported significantly higher rates of idealism than nurses from Korea.

Ethical Relativism. A significant main effect was identified for country, $F(3,1226)=33.84$, $p<0.001$, $\eta p^2=0.08$. On this measure, nurses from Japan and China reported significantly higher rates of relativism than nurses from Korea and Ireland. Thus our second hypothesis was supported.

Associations between Ideology and Religiosity. To examine the associations between ideology and religiosity, bivariate correlations were conducted. Overall, no statistically significant associations were found between either religiosity and idealism, $r(1194)=0.04$ or religiosity and relativism, $r(1193)=-0.04$ and therefore the third and fourth hypotheses were rejected. However, ethical idealism was positively associated with ethical relativism $r(1228)=0.33$, $p<0.001$. To further explore these results, we then examined the associations between these variables within each country. The similar overall pattern was observed within each of China, Japan, and Korea. Ireland was the exception where no statistically significant associations were observed between idealism, relativism and religiosity.

Discussion

In this study we explored religiosity and ethical ideology of nurses from four countries. While there was no significant association between religiosity and ideology, the results suggest that nurses' religiosity, ethical idealism, and ethical relativism differ as a function of country/culture. Future research can investigate whether these differences manifest themselves in behaviour, as is the case with physicians who identified personal values as the strongest moderator of ethical choice [40].

With regard to the religiosity measure, Irish nurses scored significantly higher than their Chinese, Japanese and Korean counterparts. This is not surprising as of the four samples; the Irish were by far the most homogeneous in terms of religious affiliation (76.6% Catholic). Under half of the Korean nurses identified as Christian; the majority of Japanese and Chinese nurses declared no affiliation. The case for China is marginally straight forward as atheism has been national policy since 1947 and religious practice of any sort was and continues to be discouraged [41]. Japan is more complex. Its religious roots are based in Buddhist and Shinto traditions, however many Japanese while accepting many of the traditions particular to these religions (births, marriage, funeral ritual, New Year's celebrations, for example), they do not identifying themselves as being religious [42]. Rather, these traditions and rituals have become part of the socio-cultural fabric of everyday Japanese life and the formal ideological and the informal experimental and consequential aspects of religiosity may be much less apparent [42]. Korean nurses fell between the Irish and the Japan/China belief systems and this may be a function of the relatively high percentage of self-declared Christians (41.8%). While we did not measure the impact religion has upon actual nursing decision-making practice, it is clear that of the four countries participating in the study, the Irish nurses may be more likely to render religious choices based on their religious convictions than their counterparts. The nursing ethics literature suggests that the world-view

of the nurse including his/her religious values and beliefs influences his/her ethical decision-making in practice [43].

In terms of ethical idealism, Korean nurses scored the lowest among the participants. Ethical idealism is the belief that positive outcomes can be realised for the majority of those involved. Gautier [44] suggested that due to the constant pressure of war with North Korea, the South Koreans resign themselves to a quiet state of fatalism that recognises the potential for conflict implicitly. Relativism scores reflect the nurses' self-declaration of religious affiliation. Recall, high scores in relativism indicate the rejection of universal norms in favour of cultural and or situational contexts for ethical choices. Low scores suggest an acceptance of universal beliefs regardless of context. The latter is descriptive of Christian traditions that claim the existence of one god and his son whom he sent to save all of humanity. Nurses from Ireland in particular and Korea are dominated by Christian traditions and therefore predictably are less accepting of relativistic solutions than their Japanese and Chinese counterparts [45]. Furthermore, the traditional approach to ethics education in Ireland would have emphasised an approach centred around ethical principles and reflective of modernist ethical theories rather than from within the postmodernist theories linked with relativism [46]. Such traditional approaches to nurse ethics education is identified in the international nursing literature [47,48].

Conclusion

The world of the nurse is as challenging as it is exhausting and complex. Religious background and multicultural perspectives of the patient and staff create situations that no organisational algorithm can predict or control. In attempt to shed some light on this complexity, we investigated the religiosity and ethical ideology of a sample of nurses from China, Ireland, Japan, and Korea. The findings demonstrate that variation exists among countries in both of these constructs that lead us to question the influence and interaction between an individual's ethical orientation, belief system, and actual behaviour. Nurses from different cultures face different priorities and challenges. Despite these challenges, they have worked to reach consensus in the international arena through professional organisations such as the International Council for Nurses [49] and the International Care Ethics Observatory. Further international investigation to determine whether or not religious affiliation and intensity and/or ethical ideology have a direct impact nursing practice could help to inform international debate within the profession. Given that religious belief and ethical ideology may put a nurse at odds with institutions or peers, and given that such conflict can result in negative consequences such as burnout or moral distress, it is clear that these potential areas of conflict are important topics for further investigation. Such work could result in the creation of curricula and institutional norms that accurately reflect and respond to the lived reality of nursing practice and ultimately improve patient care [50].

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