CONCEPT OF CONSCIENCE

AMONG SLOVENE NURSES

A two parts study

Part 1: Literature review (15 ECTS on level 41 – 60 Swedish credits)
Part 2: Empirical study (15 ECTS on level 61 – 80 Swedish credits)

Master Thesis 30 ECTS
Caring Science
No: HAL- 2005:09

Author: Klavdija Peternelj, R. N.

Supervisor: Liisa-Palo Bengtsson, PhD, RN
Examiner: prof. Sirkka-Liisa Ekman, PhD, RN
Abstract

Overall aim of this study was to describe the concept of conscience and to find out how Slovene nurses understand it. In the first study (1) specific aims were to systematically review the presence of the concept of conscience in research about nurses in literature sources and in second study (2) to describe how Slovene nurses perceive and explain the concept of conscience. Research methods used were (1) literature review and (2) quantitative survey. Into (1) sample, 6 primary sources discussing concept of conscience within a nursing research project were included. In second study target population were all registered nurses and nurse assistants employed in Slovenia. Sample (2) contained 2500 nurses form the membership list of Nurses Association of Slovenia and it was standardized systematic sample with a sampling interval 5. With 483 returned questionnaires the response rate was 19,3%. Conscience questionnaire contained 17 statements and respondents were marking their level of agreement. Crombach’s alpha coefficient for the scale was 0,6492. Results showed that (1) nurses often confront their conscience when performing nursing. They are listening to their inner voice. There were no controversies among defended results identified. Articles had coherent structure, except one. (2) Slovene nurses have difficulties to act as conscience directs them at work place. Reasons for that could be found in Slovene nurses’ subordination to physicians, where nurses rarely get the opportunity to express their own ideas. The integrity of their conscience seems to be limited. At the same time they do not need to suppress conscience at work. It has showed that Slovene nurses are occupied with thinking about how things are done and how they should be done. Majority of Slovene nurses do not feel pain of conscience every day. They think that conscience needs to be interpreted and cannot be avoided. It protects us against hurting others and ourselves. Conscience should be obeyed without considering opinions of others.

**KEY WORDS:** conscience, nurses, Slovenia
TABLE OF CONTENTS

1. GENERAL INTRODUCTION ....................................................................................... 1

2. BACKGROUND ............................................................................................................... 1
   2.1. THEORETICAL BACKGROUND ............................................................................. 1
       2.1.1. Descriptions of concept of conscience ...................................................... 1
       2.1.2. Formation and internalization of conscience ............................................. 3
       2.1.3. Functioning of conscience ......................................................................... 5
       2.1.4. Inalienability of the right of conscience .................................................... 7
       2.1.5. Conscience and religion ............................................................................ 8
       2.1.6. Guilt, shame and conscience ................................................................... 10
   2.2. CONSCIENCE AMONG NURSES ......................................................................... 11

3. AIMS ............................................................................................................................... 13

4. PART I LITERATURE STUDY .................................................................................. 14
   4.1. METHOD ................................................................................................................ 14
   4.2. SELECTION .......................................................................................................... 14
   4.3. DATA ANALYSIS .................................................................................................. 16
   4.4. RESULTS ............................................................................................................. 17
   4.5. DISCUSSION ....................................................................................................... 20

5. PART II EMPIRICAL STUDY .................................................................................... 22
   5.1. STUDY DESIGN .................................................................................................... 22
   5.2. INSTRUMENTS AND SAMPLE ............................................................................ 22
   5.3. ETHICAL CONSIDERATIONS ............................................................................. 24
   5.4. DATA COLLECTION AND DATA ANALYSIS ....................................................... 25
   5.5. RESULTS / FINDINGS ......................................................................................... 25
   5.6. DISCUSSION ....................................................................................................... 29

6. METHODOLOGICAL CONSIDERATIONS ........................................................ 31
   6.1. INTERNAL RELIABILITY ..................................................................................... 32
   6.2. VALIDITY OF CONSCIENCE QUESTIONNAIRE ................................................ 33

7. GENERAL DISCUSSION ........................................................................................... 35

8. IMPLICATIONS AND CONCLUSION .................................................................. 37

9. REFERENCES ........................................................................................................... 38

10. APPENDIXES ............................................................................................................ 41
    APPENDIX 1 ............................................................................................................ 41
    APPENDIX 2 ............................................................................................................ 44
    APPENDIX 3 ............................................................................................................ 46
1. GENERAL INTRODUCTION

Historically, the concept of conscience is present in all societies but its content is continuously changing. Ethical and religious meaning of conscience has many different functions; it is good or bad, commanding or warning, elevating or condemning, battling or indifferent (Tillich, 1963), it can have control function or can even torment. Through conscience some objective structure of demands are shown and in the same time it means most subjective self-interpretation of personal life.

The place, use and development of conscience as a moral guide are far from straightforward. The concept of conscience is a creation of the Greek and Roman spirit. Whenever this spirit has been influential, notably in Christianity, conscience is a significant notion. Greek word syneidenai (“knowing with” i.e. with oneself, being witness of oneself) was common in popular language long before the philosophers utilized it. It described the act of observing oneself, often judging oneself. In philosophical terminology, it received the meaning of “self-consciousness” (Tillich, 1963). According to Goldberg (2004), in many languages, the word conscience is closely linked with the concept of consciousness; both imply the capacity to know with.

This paper describes theoretical background and two-part study. First study is systematic literature review and will support second study, which is a survey about comprehension of conscience among Slovene nurses.

2. BACKGROUND

2.1. Theoretical background

2.1.1. Descriptions of concept of conscience

A human can make judgments about the way he or she acts in the world. This is one's personal yes or no about any course of action considered. Every affirmation, every consciously known and possessed judgment, has a moral dimension, since it reveals the disposition of a free and responsible person. Persons own our judgments and actions. Since
these judgments are not automatically forced from persons, they take the form of “I ought” or “I should.” They are judgments of conscience, which appear in statements like “I ought to do this action” (Kavanaugh, 1997).

The essence of conscience is the capacity to look beyond the limitations of the moral values one has introjected and to envision a more compassionate and noble way of being with other people (Goldberg, 2004). Usually we speak of “conscience” as the reflection we do prior to action. But an older meaning of conscience is still operative. Conscience tells us retrospectively whether what we did was right or wrong. Our conscience confirms us or “bothers” us (Vacek, 2002).

Conscience is described in different ways, most often in connection to human morality although it does not support any particular moral theory. Conscience is often discussed in this way for its primacy in our moral lives. For Aquinas conscience is a mind of a person making moral judgments. When the mind of a person makes a moral judgment, the appropriate conclusion of the process will be the action, which conforms to that judgment (Leal, 1999). Gaylin (1994) defines conscience as the equivalent of a “good heart” or a “good will” and is foundation of moral strength, as Buber understands it (Ledermann, 1982). For Baker conscience is a person's system of moral values, standards of behavior, sense of right and wrong (Rose, 1999). Conscience is linked to concern about compliance with standards of conduct, apology, confession and reparation, as well as empathy and prosocial themes, and concern about social relationship (Kochanska, 1994). Similarly also for McConnel (1996) conscience is not a special faculty that is a source of moral knowledge. It is the act of applying one's moral beliefs to one's own conduct. Conscience is not itself a standard; rather appeals to conscience involve an agent reflecting on his own past or (projected) future behavior and assessing that behavior in light of this own standards. Baker (Rose, 1999) also defined conscience as a person's system of moral values, standards of behaviour, sense of right and wrong. Its elements consists of a sense of accountability, including both responsibility for past actions and feelings and obligations in regard to future ones, a capacity for self-criticism, and standards and ideals (Rose 1999).

Conscience is also described in connection to human authenticity. Heidegger sees conscience as vacillation between presence and absence and predicates conscience's existential mode of “holding for true” on the dynamic advent of truth as concealing-revealing. It is the self's
readiness to cultivate death as a possibility and addresses conscience as a voice which the self
both utters and heeds. Conscience is in not a human mode in which the voice of God becomes
present, but rather the recoil from absence, which prefigures any turn toward enlightenment
and self-discovery. Conscience is attributed to a being, which exists in the decisive sense as
standing out toward possibilities (Schalow, 1995). Similarly for Crowell (2001) conscience is
both a genuine first-person mode of self-awareness and the origin of reason as that which
distinguishes factic “grounds” from normative “justification.”

For Ledermann (1982) conscience means the capacity and tendency of man to distinguish
radically between those of his past and future actions which should be approved and those
which should be disapproved. Theologians and psychologists see it as the reaction of our total
personality to its proper functioning and disfunctioning, not to the functioning of this or that
capacity but to the capacities, which constitute our human and individual existence. Most
accept conscience as more than just one faculty (Hoose, 1999). Social learning theorists are
justifying conscience to be conceptualized as a conditioned reflex (Crittenden, 1990 after
Rose, 1999).

2. 1. 2. Formation and internalization of conscience

Conscience is laid down during the prolonged period of dependency that distinguishes the
human being from all other animals and requires the presence of caring adults. Without the
presence of caring adults, conscience mechanisms are the first underlying attributes of
humankind (along with a capacity for empathy and attachment) to be damaged, limited, or
destroyed altogether (Gaylin, 1994). Lack of adequate conscience development is a grave
societal concern. The children emotionally experience their parents; therefore they eventually
have no other choice except to accept the physical and psychological superiority of their
parents, if they wish to enjoy parental investment and teaching. The child adopts parental
standards with their precepts and prohibitions due to the fear of the loss of love and/or
abandonment. The conscience is formed within this structural dilemma. The willingness to
obey depends on the child’s emotional relation to mother and father. The conscience is
willing to provide impulses for ethical and altruistic behavior even long after the death of the
parents.
The conscience comprises originally external ideas concerning standards, values, and morals, which are actively processed in the internalization process of a child’s ego. Cultural, social, and especially parental ideas and standards of behavior receive an individually shaped and specific quality. Especially significant is how a child individually experiences the parents and their values, rules, and standards. They appear in the individual’s conscience as subjective moral convictions and orientations for behavior. Moral values develop through identification with parents and also through identification with larger family, community, religion and greater culture (Meyer, 1998). An especially important aspect of early relationships for a child’s learning about emotions and morality is discourse with parents. Discourse enables parents to make explicit the hidden and often confusing psychological world that underlies behavior, relationships, morality, and self-understanding (Thompson, Laible, & Ontai, 2003 after Laible, 2004).

Parents should raise children to develop healthy or caring-constructive conscience and avoid developing a self-limiting and destructing conscience. Human service professionals should promote the development of a healthy conscience as an aim of their work with parents and children. As such, they may ultimately have a positive impact upon other social problems, including conduct disorder and antisocial behaviour (Rose, 1999).

Emerging signs of conscience and internalization appear in early childhood. Toddlerhood is especially important as the context for internalisation. The foundations of conscience develop in the first three years of life. (Kochanska, 1994). Conscience development is facilitated by passive temperamental inhibitory systems, which encompass anxiety, shyness, fearfulness and inhibition to the unfamiliar (Kagan, 1989 after Rose, 1999) and active temperamental inhibitory systems, which encompass effortful impulse control (Rothbart, 1989 after Rose). Developmental processes contribute to the emergence of an internalized conscience in children (Kochanska, 1994):

- Affective process - development of the ability to experience discomfort, guilt, remorse, self-criticism, and anxiety associated with actual or anticipated wrongdoing.
- Growth of self-regulation so as to refrain from committing a transgression, resisting temptation, over-coming a forbidden impulse, and performing an acceptable action instead of performing an unacceptable one.
2. 1. 3. Functioning of conscience

Development of the reality as well as of the concept of conscience is connected with breakdown of primitive conformism in a situation that forces individual to face himself as such. Nietzsche is pointing to the sub personal character of guilt and punishment in primitive cultures and praises the discovery of the conscience as the elevation of mankind to a higher level. The fact that self and the conscience are dependent on the experience of personal guilt explains the prevalence of the »bad conscience« in reality, literature and theory. It supports the assertion that the uneasy, accusing, and judging conscience is the original phenomenon, that good conscience is only the absence of bad conscience and that the demanding and warning conscience grow in mutual dependence. Since the self discovers itself in the experience of a split between what is and what it ought to be, the basic character of the conscience – the consciousness of guilt – is obvious (Tillich, 1963). Tillich uses the terminus “bad conscience” which is the same than terminus “pain of conscience” which is used by others.

The call of conscience says nothing according to Heidegger. By saying nothing, the call provides the necessary provocation to awaken the self to its own possibilities, including the unique prospect of death. Only in keeping silent does the conscience call, that is to say the call comes from the soundlessness of uncanniness. Silence is as the distinctive trademark of conscience's call, as a tribute to the ultimate economy of speech. Conscience as a silent call becomes an emissary of nothingness (Schalow, 1995).

It is the presence or absence of constraints of conscience that controls the basic selfish "instincts" for survival mediated by fear and rage. The psychopath represents the conscience-free individual at his extreme (Gaylin, 1994). Not harmony with the universe, but the sympathy with the other man is the basis of conscience. We identify ourselves with the other man and take their approval or disapproval of our actions as our own judgement. (Tillich, 1963).

Conscience can be misled by distortions, lies, ignorance or propaganda. It can, like any judgment, be distorted by fear, force, terror, deprivation, addiction or psychological distress (Kavanaugh, 1997). Levy (1999) claims it may also be greatly assisted or retarded, improved or corrupted, by education, instruction, example, and by the society and conversation of men,
which, like soil and culture in plants, may produce great changes to the better or the worse (Levy, 1999). But even in these cases, it is still person’s judgment as an individual agent that person must ultimately own and on which the person must act. And it is only person’s own conscience, misinformed or not, that is express in moral behavior. All such behavior is a revelation of personal responsibility before the world (Kavanaugh, 1997). Conscience can naturally distinguish and if necessary condemn in such a manner not merely deeds, but also omissions, not merely decisions, but also failures to decide, indeed even images and wishes that have just arisen or are remembered (Ledermann, 1982).

Conscience may be called transmoral if it judges not in obedience to a moral law, but according to its participation in a reality that transcends the sphere of moral commands. From the existentialists point of view conscience summons us to ourselves, it has no special demands and it speaks to us in the mode of silence. The good, transmoral conscience consists in the acceptance of the bad, moral conscience, which is unavoidable whenever decisions are made and acts are performed (Tillich, 1963).

Tillich (1963) argues that conscience points to an objective structure of demands, that makes themselves perceivable through it, and represents, at the same time, the most subjective self-interpretation of personal life in relation between the form and the content of conscience.

We have the same reason to trust conscience, as we have to trust other faculties, such as the senses, and are under the same necessity of doing so. There are two claims: that we have the same reason and we are under the same necessity. Several faculties are mentioned, but if pride of place is given to any, it is to the external senses. It assumes that external senses are trustworthy, and than moves, in the name of consistency, to conscience. Reid says that we are born under necessity of trusting our faculties. These necessities often seem fairly explicit to be the reason for trusting our facilities (Levy, 1999).

Heidegger suggests that conscience involves the response of troubling oneself to take care of the troubling situation (Schalow, 1995). Gaylin (1994) argues that human beings are much more profoundly motivated by emotional appeal than by rational choice, then the only way in which knowledge may truly inform conduct is through those emotions that support the good will, the good heart, and the conscience of the individual. In other words, knowledge will influence behavior in that person who wishes the good and is committed to pursuing it. This
kind of behavioural change through knowledge has come to be called, since the onset of the feminist movement, "consciousness-raising." It is a potent force for changing behavior. Gaylin thinks that lacking good will, the knowledge alone would not change one’s behaviour, but only fear of the punitive action of the law will work here.

The first principles of morality are obtained by what Reid calls conscience, the moral faculty, the moral sense or intuition. To receive the testimony of conscience that conscience is to be trusted, and that it is not fallacious. Raid says that conscience is not fallacious, he means that there are moral facts and that, when carefully used, conscience is a reliable guide to them (Levy, 1999).

Thomas Aquinas himself noted that even if one's conscience is misguided, it ought nonetheless to be followed, unfortunate as that may be. For a murderer may be both sincere and conscientious while at the same time being a misguided menace. Aquinas insists that conscience is not a faculty, but the activity of judging, a function of intelligence (Kavanaugh, 1997).

2. 1. 4. Inalienability of the right of conscience

An inalienable right is own, which means that may not be waived or transferred by its possessor. He does not have the moral authority to give up the right deliberately. To say that the right of conscience is inalienable is to say that one should bind oneself irrevocably to follow the commands of oneself. Alienating the right of conscience is giving up completely the right to act on one’s own moral decisions and is not morally acceptable option. To give up one's right of conscience is to give up irrevocably the right to act on one's own moral judgements. The inalienability of the rights of conscience does not preclude one from obeying the commands of others (McConnel, 1996). Kavanaugh (1997) and Costigane (1999) agree that a judgment of conscience can only be made by the person who owns and utters it. It is a pre-eminently personal thing. Thus, no one can claim possession of another's conscience. Somehow it is a function of a reason, and is something, which relates to the individual, but conscience’s working cannot be seen in isolation and divorced from the wider community. Conscience is mostly something which relates to the individual. Conscience is personal; it
relies on the freedom of existence. As Ledermann (1982) says, freedom is exercised in carrying out the demands made by conscience.

One who is said to have a well-developed conscience has a disposition to act in accordance with his moral beliefs. Such a person is said to have integrity, and this means that the person has properly integrated his actions and beliefs. Appeals of conscience occur typically in cases of conflict. Temptation to act contrary to own moral beliefs may invoke conscience in the hope of bolstering person’s strength of will. Here the conflict is within oneself. Person has a right to act on own moral beliefs. So if there is a right of conscience, there is a moral presumption, albeit overridable, that person should be free to act on own moral beliefs (McConnel, 1996). The quest for freedom of conscience does not refer to the concrete ethical decision, but to the religious authority of the inward light that expresses itself through the individual conscience (Tillich, 1963).

2. 1. 5. Conscience and religion

Conscience is ethical concept and has a basic significance for religion in relation between objective and the subjective sides of conscience. Freedom of conscience actually means the freedom to follow one's autonomous reason, not only in ethics, but also in religion (Tillich, 1963). Views of Roman Catholic and Protestant churches are presented. Aquinas or Luther conscience is not a religious source. They all keep the authority of conscience within the ethical sphere. »Assurance of faith« is not a matter of conscience (Tillich, 1963). Conscience is more catholic concept (quality of work) than protestant concept (quantity of work).

2. 1. 5. 1. Roman Catholic view

God’s calling, resounding in an individual’s heart, is seen as both a religious experience and an experience of conscience. Conscience is a faculty possessed by all individuals, the faculty by which they evaluate the moral worth of their behaviour in the light of their beliefs. It is not just a retrospective faculty but also is having a role in making decisions in advance of an action. Individuals acting in accordance with their conscience would stand by their inner convictions, whilst not imposing their actions and convictions upon others, or criticizing those whose convictions and actions differ. The subjective aspect of conscience is strongly affirmed
as a norm for behaviour, the force being derived from the individual’s personal perceptions of morality and the objective reality of God and his expectations of human beings (Hoose, 1999).

The Roman Catholic tradition derives its understanding of conscience by including the central core of the person, the awareness that one should do good and avoid evil and the faculty to work out what is right and what is wrong. According to Hoose (1999), each person is seen as having God’s law inscribed on his heart, a law, which is detected deep within a person’s conscience, and a law, which is not self imposed, but must be obeyed. Man has an infallible knowledge of the moral principles, the natural law, but he has a conscience that is able to fall into error in every concrete situation. In order to prevent dangerous errors, the authorities of church give advice to the Christians, especially in connection with the confession in the sacrament of penance. In this way, conscience became more and more dependent on the authority of the church. The immediate knowledge of the good was denied to the layman. Since the enthusiasts understood this divine voice within us in a very concrete sense, they identified it with conscience. In this way conscience became a source of religious insight and not a simply a judge of moral actions (Tillich, 1963).

There are different ways of understanding conscience in Roman Catholic tradition. Firstly conscience gives characteristic of being human which provides us with the capacity for knowing and doing good and avoiding evil i.e. general orientation to good. Secondly conscience discovers operative moral values and the right thing to do, considers the relevant moral factors. Thirdly conscience moves us form perception and reasoning to action and it judges of what the person must do in a particular situation and the commitment to do it. Conscience can be the only sure guide for action by free and knowing person. To violate this kind of conscience is to violate one’s personal integrity. A healthy conscience occurs where the whole person functions in harmony, which includes the emotional, the intellectual and the energies of will (Hoose, 1999)

2. 1. 5. 2. Protestant view

Where there is a possibility of evil action, the good person is not the one who, noticing the possibility, rejects it by an act of will, he or she is likely not to notice it at all. Much of the time, the good moral agent may not be conscious of “willing” at all. Existing under a state of
self-judgement, an individual may now speak of “having a bad conscience.” We may see that to be conscious in the weakened sense of pure “awareness” or the slightly richer sense of “self-awareness” is a necessary precursor to the exercise of conscience in the technical sense of moral thinking. Right conscience constitutes both an awareness of moral truth and some kind of awareness that it is moral truth (Leal, 1999).

German Grisez (adopted from Leal, 1999) distinguishes three approaches to the nature of conscience. In personal approach origin and justification of the principles lies in the need to conform and gain affection. Perception of norms is governed by social convention and prejudice in cultural approach and objective arena of moral value, task of growing in moral maturity in absolute approach. This contains also true moral norms, transforming partial and relative conscience into right and conscience which judges according to moral truth.

Classification of conscience starts with purely reactive conscience which responses to an already past action or decision. Minimal conscience contributes to a formation of character with respect to future acts. The painful memory of past guilt is likely to prevent one from being ready to perform an action of a similar type again. Articulate conscience is understood as the process of conscious reasoning towards or about action and relates to self-conscious moral knowledge and the regulation of conduct. Conscience as reflexive moral character means having the same attitude and relationship to oneself (Leal, 1999).

2. 1. 6. Guilt, shame and conscience

Conscience makes a judgement on actions performed or about to be performed, and inflicts pain when the individual becomes conscious of wrongdoing (Costigane, 1999). Not obeying one’s conscience leads to feelings of guilt and shame. Guilt is an unpleasant feeling arising when one has violated a personally relevant moral or social standard. Aggressive, hostile behaviors and a feeling of moral inadequacy are common sources of guilt feeling (Mosher, 1979). It is the common result of an action, where a person acts contrary to conscience. Speaking of denying conscience, one is merely talking about acting contrary to conscience. Wishing to do well, man could act contrary to his conscience in the face of intense guilt. He would simply say that his conscience, and his sense of guilt, were not trustworthy (Levy, 1999). Guilt and conscience allow us to evaluate current, past and future actions, and to
decide in advance, which of these should be approved and which disapproved. Failure to measure up can cause a feeling of guilt and that can motivate behaviour, but only in individuals with a developed capacity to feel guilt. With possessing guilt, shame, pride we leave the general animal host and enter a domain that is exclusively human. These emotions will become the ingredients of conscience and through it the motivating force for primary morality (Gaylin, 1994).

Feeling of guilt is usually linked to the conviction of having injured someone or broken some moral imperative or norm (Miceli, Castelfranchi, 1998). Guilt is evoked by failure to fulfill norms of the role of reciprocity and shame is evoked by status incongruity. Bad feelings associated with violation of role reciprocity are interpreted as guilt, and bad feelings associated with shortfall on a status-prescribed role are interpreted as a shame (Gore, Harvey, 1995). The affective state of shame is linked to a mental representation of an externalised shaming object. This is the experience associated with feeling humiliated or mortified. Shame has an interpersonal quality (others will think me bad). In guilt, the disapproval is experienced as a mental representation of the self-pronouncing the negative judgement (I am bad) (Meyer, 1998).

2.2. Conscience among nurses

There is very little written about how is it with the conscience among nurses. Curtin (1993) emphasizes, the problem of maintaining integrity of conscience is particular troublesome to nurses. Moral persons need social space, otherwise outward behaviour and job descriptions will drive professional, moral, and religious ideals or beliefs into irrelevant inwardness, and personal integrity will be destroyed (Curtin, 1993).

Forcing health care professionals to engage in activities that they find morally reprehensible, simply because they have undertaken a certain profession is not infrequent. Protection of professionals moral conscience within the context of their professional obligations must be assured and not make this a function of social utility. A liberal society is concerned with protecting an individual's moral conscience. A liberal society recognizes no privileged perspective of moral value that might be enforced. Each individual is reserved the right to live his life according to values he adopts for himself (so long as he does not harm others in doing
so). Kavanaugh (1997), Costigane (1999), Tillich, 1963 and Ledermann (1982) took the same position about inalienability of conscience. What one person believes is morally required, then, may be seen by another morally prohibited if the value systems of the two are different enough (May, 2001).

Sometimes conscience seems to be more than awareness of wrongdoing, or something that pains because of this awareness. Those with vulnerable consciences perform an action, seeing that others do it, but are afflicted in a way in which the others are not (Costigane, 1999).
3. AIMS

Overall aim was to describe the concept of conscience and to find out how Slovene nurses understand this concept.

Specific aims were:

Study I
To systematically review the presence of the concept of conscience in research about nurses in literature sources.

Study II
To describe how Slovene nurses perceive and explain the concept of conscience.
4. PART I LITERATURE STUDY

4.1. Method

Literature review is the selection of available documents on the topic (both published and unpublished), which contain information, ideas, data and evidence written from a particular standpoint to fulfill certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed (Hart, 1998). The literature itself is the subject of discussion and its aim is to generate as comprehensive a list as possible of primary studies, which may be suitable for answering the questions posed in the review (Kahn et al, 2001).

The reasons for beginning a literature review before starting a research paper are:

- to see what has and has not been investigated,
- to develop general explanation for observed variations in a behaviour or phenomenon,
- to identify potential relationships between concepts and to identify researchable hypotheses,
- to learn how other researchers have defined and measured key concepts,
- to identify data sources that other researches have used,
- to develop alternative research projects,
- to discover how a research project is related to the work of other researchers.

(http://www.library.ncat.edu/ref/guides/).

This review aims to be comprehensive, covering all nursing research on concept of conscience. Comprehensive knowledge of the literature in this field is essential to most research projects. Type of conducted review is dealing with issues of quantitative and qualitative research within the sphere of conscience.

4.2. Selection

The collection of information took place from 4th to 6th of June 2004. A systematic computerised literature search was performed in the electronic databases CINAHL, Medline, MUSE and PsycINFO. The purpose was to find material describing concept of conscience in
nursing research. Enters were “conscience”, “nursing” and its root “nurs*”. The search was carried out thoroughly and it was wide enough to provide all the relevant material. Probability that electronically narrowing would exclude also relevant sources was high. Sources were therefore skim read to exclude irrelevant material. Sensitivity of the search was high; therefore level of precision was consequently low. Number of hits in literature search is presented in Table 1.

<table>
<thead>
<tr>
<th>Number of hits</th>
<th>CINAHL</th>
<th>Medline</th>
<th>Psych-INFO</th>
<th>MUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>All fields “conscience” and “nursing”</td>
<td>237</td>
<td>194</td>
<td>13</td>
<td>/</td>
</tr>
<tr>
<td>All fields “conscience” and “nurs*”</td>
<td>265</td>
<td>232</td>
<td>23</td>
<td>/</td>
</tr>
<tr>
<td>Abstract “conscience” and “nurs*”</td>
<td>54</td>
<td>58</td>
<td>23</td>
<td>/</td>
</tr>
<tr>
<td>All fields except text “conscience”</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>42</td>
</tr>
<tr>
<td>Total number of included sources after reading article citations</td>
<td>35</td>
<td>25</td>
<td>17</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 1. Number of hits in literature search

Primary sources were included in accordance with the aim of the study that the articles within a nursing research project discuss concept of conscience. Review includes only peer-reviewed articles in English.

Selection of sources was carried out in three steps. First, databases were searched. After typing in the key words, the citations of the set of potentially useful sources were read through and in the context to the criteria of inclusion, articles were included or excluded with regard of their relevance. 144 publications were initially identified as relevant to the substantive research question. For analysis 84 of 144 articles were found to be relevant and included in further analysis. However, many of them were duplicated in different databases. Therefore, duplicates were excluded. Second step was reading source abstracts and after that nine sources included in third step. Three of those nine sources were not possible to obtain from publisher and were also not available otherwise. In the third step the obtained sources, which proved to be all scientific articles, were first skimmed through for relevance and than analytically read. Six articles were included into final integration and analysis. Integration was difficult for a number of reasons. Included sources and their qualities are presented in Table 2.
4.3. Data analysis

The used literature was critically analysed and followed through a set of concepts and questions, comparing items to each other in ways they deal with them. Matrix method was used. Items were listed and summarized. Then, strengths and weaknesses were discussed. It was described what knowledge and ideas had been established. Unequivocally, contrasting perspectives and viewpoints about conscience were not revealed.

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aim</th>
<th>Method</th>
<th>General results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthur D, Pang S, Wong T. (1998) Contemporary Nurse 7(4), 198-204</td>
<td>Caring in context: caring practices in a sample of Hong Kong nurses</td>
<td>To explore and validate some of the meanings of caring among nurses in Hong Kong</td>
<td>Descriptive, quantitative 77 registered nurses 57% response (77 of 136) Open-ended questionnaire Content analysis coding procedures</td>
<td>Highlighted are the problems in attempting to use concepts such as the 5 C’s compassion, competence, confidence, conscience and commitment across cultures. Most common theme about conscience is knowing what is right or wrong, following code of ethics, moral conscience, heart feeling, being honest to your actions/take responsibility, acknowledgements of moral standard and intuitive knowledge.</td>
</tr>
<tr>
<td>Berggren I, Severinson E (2003) Journal of Advanced Nursing 41(6): 615-623</td>
<td>Nurse supervisors’ actions in relation to their decision-making style and ethical approach to clinical supervision</td>
<td>To explore the decision-making style and ethical approach of nurse supervisors by focusing on their priorities and interventions in the supervision process.</td>
<td>Descriptive, qualitative 4 clinical nurse supervisors Focus group interview Hermeneutic content analysis</td>
<td>The essence of the nurse supervisors’ decision-making style is deliberation and priorities. The nurse supervisors’ willingness, preparedness, knowledge and awareness constitute and form their way of creating a relationship. The core components of nursing supervision interventions are: guilt, reconciliation, integrity, responsibility, conscience, and challenge. The nurse supervisors’ interventions involved sharing knowledge with the supervisees and recognizing them as nurses and human beings.</td>
</tr>
<tr>
<td>Nelms TP. (1996) Journal of Advanced Nursing 24(2): 368-74</td>
<td>Living a caring presence in nursing: a Heideggerian hermeneutical analysis</td>
<td>To illuminate nurses’ shared practices and common meanings of living a caring presence in nursing</td>
<td>Descriptive, qualitative 5 nurses Written story of living a caring presence Heideggerian hermeneutics analysis</td>
<td>Meaning and complexity of the pattern were revealed in themes that illuminate and articulate the essence of nursing and the phenomenon of caring. Themes were the timelessness and spacelessness of caring, creating home, and the call to care as the call of conscience.</td>
</tr>
<tr>
<td>Sørlie V, Jansson L, Norberg A (2003) Scandinavian Journal of Caring Sciences 17(3): 285-292</td>
<td>The meaning of being in ethically difficult care situations in paediatric care as narrated by female registered nurses</td>
<td>To illuminate the meaning of female registered nurses lived experience of being in ethically difficult care situation in paediatric care.</td>
<td>Descriptive, qualitative 20 female registered nurses In-depth interview Phenomenological-hermeneutic</td>
<td>Nurses appreciated social confirmation from their colleagues, patients and parents very much. They missed self-confirmation from their conscience, which gave them an identity problem. They were regarded as good care providers but at the same time, their conscience reminded them of not taking care of all the “uninteresting” patients. This may be understood as ethics of memory where their conscience set them a test. The emotional pain nurses felt was about remembering the children they overlooked, about bad conscience and lack of self-confirmation. Nurses felt lonely because of the lack of open dialogue about ethically difficulties.</td>
</tr>
</tbody>
</table>
Meeting ethical challenges in acute care work as narrated by enrolled nurses

To illuminate the experience of enrolled nurses being in ethically difficult care situation and working in an acute care unit

Descriptive, qualitative
5 enrolled nurses
In-depth interview
Phenomenological-hermeneutics

Reflections of enrolled nurses seem to show an expectation of care. One of the formulated themes was role of conscience. The enrolled nurses note that it is “that little bit extra” that is problem for their conscience and the bad conscience increases when they acknowledge that they are unable to do “that little bit extra”. A lack of time could lead to a bad conscience over “that little bit extra being” omitted. This lack of time could also lead to tiredness and even burnout, but the system did not allow for more time.

Perioperative nurses’ encounter with value conflicts: a descriptive study

To gain better insight into perioperative nurses’ experience in a value conflict that has arisen in the perioperative caring environment and how they deal with it.

Descriptive, qualitative
127 incidents: written down stories by perioperative nurses
Hermeneutical approach
Critical incident technique
Essence method

The nurses are prevented from giving the good care they want to give, they are in conflict with themselves and have a bad conscience, and they feel guilt and shame for not having prevented value conflict. The nurse who is involved in a value conflict aims, for the sake of the patient, to be a professional caring nurse. The nurse chooses to be the patient’s neighbour, the one who suffer along with the patient and represents the patient’s cry for help.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Journal</th>
<th>Date</th>
<th>Methodology</th>
<th>Data Collection</th>
<th>Data Analysis</th>
</tr>
</thead>
</table>

Table 2. List of included sources and their qualities

4.4. Results

Six articles were found relevant, the oldest one dating in 1996. They all had well-grounded aims and descriptive general methodological approach. The issues were adequately addressed, except the study of Arthur, Pang and Wong (1998), who stated on their own, that concept of conscience was hard to respond to in the open-ended questionnaire. They expected to get deeper and richer data, but the researchers received data of poor quality indicating the choice of unsuitable data collection method. Overall, data was collected using in-depth interview (2 sources), questionnaire – writing stories (2 sources), open-ended questionnaire (1 source) and focus group interview (1 source). For data analyses, following methods were used: phenomenological hermeneutics (2 sources), Heideggerian hermeneutic analysis (1 source), content analysis coding procedures (1 source), qualitative hermeneutic content analysis (1 source) and critical incident technique with essence method (1 source). The choice of the data collection and data analysis methods were substantiated in detail.

Authors discussed reliability and validity of their studies. Von Post (1998) assessed limited number of informants with various experiences in her study. To increase validity,
triangulation of researchers for identification of categories was used, which contributed to validity of results. Sørlie, Kihgren Larsson and Kihlgren (2004) described very precisely the whole research process, but were not discussing the limitations of the phenomenological hermeneutics analysis, which are known and therefore adopted. In the second study Sørlie, Jansson and Norberg (2003) discussed methodological considerations and emphasizing that given interpretation was only one of several possible. For ensuring reliability, Nelms (1996) had asked participants for feedback and they verified the credibility of the interpretations. Berggren and Severinsson (2003) pointed out that small group, which she has used, can offer smaller pool of ideas. Arthur, Pang and Wong (1998) had lots of methodological problems. They had distributed the questionnaire in English and Chinese and the responses were then translated into English. The accuracy of the translation was checked with back translation of several responses. Validity was reduced because of only 57% sample realization.

In nursing research, conscience as a concept is quite new. Berggren and Severinsson (2003) took it as one of the core components of nursing supervision interventions alongside with guilt, reconciliation, integrity, responsibility and challenge. Among authors, conscience was most often treated as originating from the person itself. For Von Post (1998) it was nurse’s intuitive awareness of what was required of her. It was wordless voice that may be seen as an inner voice (Sørlie, Kihgren Larsson and Kihlgren, 2003), or according to Nelms (1996) Heideggerian conscience was in the nature of a call to our innermost potentiality for being ourselves. Heidegger calls conscience what has the potential for helping us find our way back to authenticity is the ontological quality we live. Conscience is wordless, silent call that comes both out of and over somebody. In conscience one calls oneself, from some part of oneself that remains free from entrapment in falling. The call is precisely something we ourselves have neither planned nor prepared for nor voluntarily perform. It calls against our expectations and against our wills. And yet, the call reaches the one who wants to be retrieved and moves the one back resolutely to individualized authentic being. The call of conscience, if understood through resoluteness, recall us to an authentic openness, which in turn transforms our awareness of the world and others as Nelms (1996) was explaining.

21% of Hong Kong nurses in the sample believe that conscience is “knowing what is right or wrong”(Arthur, Pang and Wong, 1998) and they come into conflict with their own conscience because they know that (Von Post, 1998). They are in a value conflict and the person in a value conflict gives herself a bad conscience and takes on the guilt and the responsibility for
what happened to the patient. It may be concluded that a value conflict is a difficult conflict that has developed within the nurse when she is witness to a situation where the patient’s dignity has been violated. The nurse’s inner conflict may be understood as a conflict between her will to do good, wanting to care in caring, and the taking part against her own will in a care from which caring has been excluded (Von Post, 1998). In the Hong Kong study, other most common themes regarding conscience were “following codes of ethics” 12%, “moral conscience” 12%, “heart feeling” 10%, “being honest to your actions / take responsibility” 9%, “acknowledgements of moral standard” 8% and “intuitive knowledge” 5%. Roach’s theoretical framework was used, which expressed caring as the human mode of being. Caring behaviour in nursing is manifested through the attributes of compassion, competence, confidence, conscience and commitment; the 5 Cs of professional caring. According to Roach (Arthur, Pang and Wong, 1998), conscience is a state of moral awareness; a compass directing one’s behavior according to the moral fitness of things.

Conscience gives approval for actions taken and according to Sørlie, Kihgren Larsson and Kihlgren (2004), nurses missed the confirmation from their conscience, which gave them identity problem. Nurses are socially confirmed by performing the tasks expected from them, but they have rather bad conscience. They are regarded as good care providers, but at the same time they hear a wordless voice accusing them of not caring. Conscience reminds nurses of what they are or are not. It is reasonable to assume that nurses have a feeling of not being good nurses for all patients in the unit, thus they need self-confirmation – an inner voice telling them they are good enough – a confirmation that is given by their own conscience. It is not enough for nurses to get social confirmation from colleagues or some of the patients or their parents. The emotional pain nurses feel is about remembering the children they overlook, about bad conscience and lack of self-confirmation. Nurses see the ethical problems connected with their current practice but are unable to change it, therein lies a source of bad conscience.

Role of conscience emerged also in second Sørlie’s study. The recognition that they are unable to meet personal standards of care, results in dilemmas of conscience for the enrolled nurses. As human beings they are split into two. In part, enrolled nurses accept that what they are actually doing is adequate, but also partly recognize that this is not up to the standard they want to meet. Enrolled nurses note that it is “that little bit extra” that is a problem for their conscience. The bad conscience increases for the enrolled nurses when they acknowledge that
they were unable to do “that little bit extra”. The enrolled nurses continue, apparently unchanged by their qualms of conscience. They do recognize that they become increasingly tired and that burnout can result from this.

4.5. Discussion

As studies demonstrate, nurses often confront their conscience during performing nursing. They listen to their inner voice, knowing what is right and what is wrong. Environment they are working in increases the possibility to have bad conscience and to be in conflict with their own. As theoretical framework, twice Heideggerian advocacy of conscience was used and once Roach’s model of caring.

Taken as a whole, there were no controversies in defended results. They are all going in the same direction. There is also no trend showing that there will be more nursing research done on the subject of conscience in the future since there were three researches published in 1996 and 1998 and other three in 2003 and 2004. All studies compared are useful, however, only few studies offer real richness of data.

Consistency of the studies was also studied, mainly the connection between title, aim, method and findings. The title of Arthur, Pang and Wong (1998) study would have to be reconsidered since the title is describing caring practices in Hong Kong, the article, however, is reporting about the meanings of caring among nurses. Other articles had coherent structure.

The ethical issue was taken into consideration in all studies except Arthur, Pang and Wong (1998) one, where respondents could freely choose whether or not to send a questionnaire. Unlike other authors, Sørlie, Kihlgren Larsson and Kihlgren (2004) and Sørlie, Jansson and Norberg (2003) had attained approval from the ethical committee in both studies. The others had obtained informed consent to participation and were protecting integrity of informants.

Methodological limitations of this systematic literature review had showed. Review included only sources in English language and therefore results and interferences may be biased. Chosen articles are dealing with concept of conscience in very different ways. Articles were methodologically diverse and studies were containing different kind of focus on the concept
of conscience. In the article of Berggren and Severinsson (2003), for instance, conscience was quite marginal note. Restricting the search to few databases was considered appropriate to the current research question, but examining more databases would be useful for given the interdisciplinary involvement of concept of conscience. Consequently a wider search of relevant databases in philosophy, psychology, social work, sociology, medicine and nursing would be undertaken to get more items for analysis, but on a different research question of course.

Concept of conscience is now extremely rarely present in research about nurses. As this study shows researches on the topic are few and exceptional, but it could be estimated that research in connection to concept of conscience will become more present and burning question. Development of medical devices, which help to maintain human life over the limits, will force debates about nurses’ conscience, for instance. As Curtin (1993) emphasizes, the problem of maintaining the integrity of conscience is especially troublesome for nurses.
5. **PART II EMPIRICAL STUDY**

5.1. **Study design**

When interviewed about being in an ethically difficult situation, health professionals related to conscience in connection to the sphere of their action in intensive care units (Söderberg, 1999). Often the term “inner voice” or “the call” was used. They expressed that they feel pain of conscience if they for different reasons are not able to provide good care to the patients. Also it was detected that they were under stress. This facts lead to assumption that having pain of conscience can cause burnout. Concepts of conscience, pain of conscience, moral sensitivity, resilience, interpersonal relationships and burnout were predicted to influence the connection between conscience and burnout.

A research about how nurses and other health professionals are conceptualizing conscience and experiencing pain of conscience is taking place in Lithuania, Norway, Russia, Slovenia, Sweden and Unites States of America. The ongoing research is examining whether conscience differs in different cultures or it changes with age or professional experiences, and that having pain of conscience may substantially contribute to nurses becoming burned out.

This study represents a part of above-mentioned study as it was planned in the range of extensive international research under the guidance of prof. Astrid Norberg from Umea University in Sweden. Study design and questionnaire were developed and tested in Sweden and then used in Slovenia.

Within quantitative approach descriptive method was used to describe concept of conscience as perceived by Slovene nurses. Type of research is survey.

5.2. **Instruments and sample**

Questionnaire developed and tested in Sweden was used. Two different translators translated it into Slovene and then back into English. Different versions (original English and the back-translated English version from Slovene) were compared and differences discussed between Slovene and Swedish researchers until the consensus was reached. Slovene version had been changed, however, the collaborating researchers agreed there is no difference in meaning.
Cultural difference was considered as well in a pilot study that was performed among 10 nurses to see if the translated questions function well in Slovene context and that they are easy to understand. Final questionnaires were printed on a yellow paper and were composed out of questions about bad conscience, moral sensitivity, interpersonal relations, resilience and stress scale. Approximately 12 minutes were needed to fill in the whole questionnaire. Part of the questionnaire about conscience contained 17 statements and respondents were marking options previously offered by researchers. The options indicated respondent’s level of agreement. The scale ranged from “I do not agree at all” (assigned value: 1) to “I strongly agree” (assigned value: 6). Respondents could also write down their remarks in an open-ended question at the end.

Together with questionnaire about conscience, extensive questionnaire (required approximately 45 minutes to be completed) about ethics of Slovene nurses was also sent out to the same sample at the same time.

Target population was all registered nurses and nurse assistants employed in Slovenia. Members of Nurses Association of Slovenia represented achievable population and on the day of sampling, 4th of October 2003, 12,515 members were listed. In August 1999 there were 87,4% (12,039) of all nurses (13,779) in Slovenia affiliated to this association (Peternelj, 2001) and in the lattermost years the membership part did not change evidently.

Sample included 2500 nurses from the membership list and it was standardized systematic sample with a sampling interval 5 (20% of achievable population was desired to be included into sample). Starting number in sample formation was chosen anonymously out of one to five. Four members of the research group who promised to keep the secret knew the number and they carried out the sampling. With 483 returned questionnaires of 2500 sent the response rate was 19,3%.

94,6% of respondents was women (Figure 1 in Appendix 3). Nurses Association of Slovenia estimates that 5% of Slovene nurses are men (Peternelj, 2001) and as it was also in this sample.

Average age of respondents was 38,9 years ($M_o = 39,5$, $M_o = 39$). Frequency distribution of sample statistics is shown in Figure 2 (Appendix 3). There is no reliable data known about
this population parameter. According to available data the sample age distribution was normal with a peak 39 years, but as data states the age at which a nurse entered association the actual age distribution may be shifted towards higher age. Many of nurses do not become members straight on the beginning of their carriers.

54% of the nurses in the sample in contrast to 77% in population (Peternelj, 2001) have completed secondary school (Figure 3 in Appendix 3). Characteristics of the sample significantly differ from those of the population in connection with educational level of respondents. Due to this fact findings of this study can only be partly generalized to the population.

Majority of respondents work in hospital (52%) and primary health care institutions (24%) (Figure 4 in Appendix 3). 8% of respondents worked in nursing home, 3% in special institution for disabled people, 3% in private institution and 2% in school settings.

Nurses had 17,4 years of working experience on average ($M_e= 19 \text{ y, } M_o = 20 \text{ y, } \sigma = 10, 1 \text{ y})$ (Figure 5 in Appendix 3).

5. 3. Ethical considerations

It must be ensured that the research does not harm the participants. They must be protected from suffering physical and emotional harm however hard it is identifiable. Even one intensive question can cause considerable distress to respondents (Cormac, 1991) and may thus influence the rest of the results.

Ethical guidelines for nursing research in Nordic countries (2004) are the main guidelines for good standards in research that involves humans provided by basic ethical principles. Among others they emphasize:

- the principle of autonomy - in this research every respondent decided at his or her own choice whether or not to participate,
- the principle of beneficence - showing connection between stress and bad conscience could help nurses when coping with the nature of their work.
Researchers ensured confidentiality and anonymity to each participant by keeping confidential the sampling procedure, thus preventing revelation of personal identity of respondents.

Ethical approval of this study was obtained from the Commission of the Republic of Slovenia for medical ethics approved on the 7th of October 2003; number of approval is 69/10/03 (Appendix 1).

5.4. Data collection and data analysis

Data collection took place under the patronage of Nurses Association of Ljubljana, Slovenia, in October 2003. The yellow questionnaire was sent by mail with enclosed stamped envelope together with green questionnaire about ethical issues. Owner of acquired data is Nurses Association of Ljubljana, which also permits the data to be used by individual researchers request.

Collected data was coded and entered into Microsoft Excel sheet. For statistical analysis the program SPSS 11.0 Student Version (SPSS Inc., IL, Chicago, USA) was used. Descriptive statistics was used and each question was correlated with demographic data, which contained gender, age, education level, work place and years of working experiences in nursing.

5.5. Results / Findings

Results are reported from the first to the last question as they were presented in the questionnaire (Appendix 2) and collected in Table 3 and Figures 6 – 22 (Appendix 3). Statistically important differences are indicated. Of 2500 questionnaires sent 483 were returned and used for analysis.
<table>
<thead>
<tr>
<th>Statement</th>
<th>I strongly disagree</th>
<th>I pretty disagree</th>
<th>I partly disagree</th>
<th>I partly agree</th>
<th>I pretty agree</th>
<th>I strongly agree</th>
<th>Missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conscience needs to be interpreted.</td>
<td>13,6%</td>
<td>4,3%</td>
<td>10,5%</td>
<td>21,2%</td>
<td>22,9%</td>
<td>23,3%</td>
<td>4,1%</td>
<td>100,0%</td>
</tr>
<tr>
<td>To hear the conscience you have to have peace in mind.</td>
<td>24,9%</td>
<td>8,7%</td>
<td>9,1%</td>
<td>18,8%</td>
<td>17,1%</td>
<td>18,4%</td>
<td>3,1%</td>
<td>100,0%</td>
</tr>
<tr>
<td>We cannot avoid the conscience.</td>
<td>2,1%</td>
<td>1,9%</td>
<td>4,9%</td>
<td>10,3%</td>
<td>22,9%</td>
<td>55,9%</td>
<td>2,1%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Conscience protects us against hurting ourselves.</td>
<td>13,2%</td>
<td>5,6%</td>
<td>10,7%</td>
<td>13,2%</td>
<td>20,4%</td>
<td>34,8%</td>
<td>2,1%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Conscience protects us against hurting others.</td>
<td>2,7%</td>
<td>0,4%</td>
<td>4,5%</td>
<td>9,7%</td>
<td>21,0%</td>
<td>60,0%</td>
<td>1,6%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Own conscience should be obeyed without considering opinions of others.</td>
<td>3,5%</td>
<td>1,0%</td>
<td>5,6%</td>
<td>21,4%</td>
<td>24,9%</td>
<td>41,9%</td>
<td>1,6%</td>
<td>100,0%</td>
</tr>
<tr>
<td>I can tell what my conscience is saying to me on my work place.</td>
<td>6,2%</td>
<td>6,8%</td>
<td>12,2%</td>
<td>30,1%</td>
<td>21,4%</td>
<td>21,2%</td>
<td>2,1%</td>
<td>100,0%</td>
</tr>
<tr>
<td>I can follow my conscience at work.</td>
<td>2,5%</td>
<td>3,9%</td>
<td>8,9%</td>
<td>23,9%</td>
<td>32,8%</td>
<td>25,8%</td>
<td>2,3%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Conscience can give wrong signals.</td>
<td>21,9%</td>
<td>12,0%</td>
<td>14,0%</td>
<td>29,5%</td>
<td>11,1%</td>
<td>8,7%</td>
<td>2,9%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Conscience becomes silent if we are not listening to it.</td>
<td>34,8%</td>
<td>12,4%</td>
<td>9,5%</td>
<td>15,5%</td>
<td>11,5%</td>
<td>13,8%</td>
<td>2,5%</td>
<td>100,0%</td>
</tr>
<tr>
<td>I have to make my conscience silent at work.</td>
<td>44,3%</td>
<td>16,7%</td>
<td>9,7%</td>
<td>17,5%</td>
<td>6,0%</td>
<td>4,1%</td>
<td>1,6%</td>
<td>100,0%</td>
</tr>
<tr>
<td>My conscience is too strict.</td>
<td>29,1%</td>
<td>12,8%</td>
<td>14,8%</td>
<td>20,4%</td>
<td>13,6%</td>
<td>7,6%</td>
<td>1,6%</td>
<td>100,0%</td>
</tr>
<tr>
<td>Through conscience social values are expressed.</td>
<td>8,5%</td>
<td>7,6%</td>
<td>8,7%</td>
<td>21,9%</td>
<td>26,8%</td>
<td>23,9%</td>
<td>2,7%</td>
<td>100,0%</td>
</tr>
<tr>
<td>God is speaking through conscience.</td>
<td>31,3%</td>
<td>10,1%</td>
<td>9,7%</td>
<td>14,2%</td>
<td>14,0%</td>
<td>15,7%</td>
<td>4,9%</td>
<td>100,0%</td>
</tr>
<tr>
<td>When I am being obedient to my conscience, I am making progress as a human being.</td>
<td>2,9%</td>
<td>2,9%</td>
<td>6,4%</td>
<td>22,1%</td>
<td>24,1%</td>
<td>38,1%</td>
<td>3,5%</td>
<td>100,0%</td>
</tr>
<tr>
<td>I have bad conscience every day.</td>
<td>56,3%</td>
<td>22,9%</td>
<td>9,1%</td>
<td>6,2%</td>
<td>1,2%</td>
<td>2,5%</td>
<td>1,9%</td>
<td>100,0%</td>
</tr>
<tr>
<td>When I cannot fulfil my own demands to myself, I have bad conscience.</td>
<td>18,1%</td>
<td>12,6%</td>
<td>13,2%</td>
<td>26,6%</td>
<td>17,3%</td>
<td>9,9%</td>
<td>2,3%</td>
<td>100,0%</td>
</tr>
</tbody>
</table>

Table 3. Percentage and level of agreement with different statements from conscience questionnaire

46,4% nurses pretty or strongly agree with the statement “Conscience needs to be interpreted.” ($\mu = 4,09$, $M_e = 4$, $M_o = 6$, $\sigma =1,67$). Nurses with more than 20 years of working experience and older than 45 years disagree more in contrast to more educated, who tend to agree more.
24,4% of all respondents, men and those older than 45 years, do not agree with the statement “To hear the conscience you have to have peace in mind.” (μ = 3,51, M₉ = 4, M₀ = 1, σ = 1,86) at all, but 35,6% of all agree.

With the statement “We cannot avoid the conscience.” (μ = 5,22, M₉ = 6, M₀ = 6, σ = 1,15) 78,8% respondents pretty or strongly agree, those younger than 24 years agree more (86,7%). Men more often think that they can avoid their conscience.

That “conscience protects us against hurting ourselves” (μ = 4,29, M₉ = 5, M₀ = 6, σ = 1,76) 55,5% of respondents pretty or strongly agree, but the results are not very concentrated. More educated nurses tend to agree more.

With statement “Conscience protects us against hurting others” (μ = 5,29, M₉ = 6, M₀ = 6, σ = 1,13) 81% of respondents agree, which is stronger agreement than with the statement that conscience protects us against hurting ourselves.

66,3% of respondents strongly or partly agrees “own conscience should be obeyed without considering opinions of others” (μ = 4,92, M₉ = 5, M₀ = 6, σ = 1,23). Those employed in nursing homes agree less than the rest of the nurses.

One third of all respondents partly agree that they “can tell what their conscience is saying to them on their work place” (μ = 4,2, M₉ = 4, M₀ = 4, σ = 1,42). Men disagree twice as much, as well as nurses under 34 years old and those with less than 9 years of working experience. Nurses in primary health care, nurses with completed secondary nursing school, older than 45 years and nurses in school setting tend to agree more.

Overall, 58,2% of respondents agrees they “can follow their conscience at work” (μ = 4,62, M₉ = 5, M₀ = 5, σ = 1,22). Younger than 35 years, those with less than 4 years of working experience, those in primary health care settings and more educated tend to agree less. On the contrary, nurses older than 45 years agree more; nurses in school settings agree 88,8%. Those with less than 9 years of working experience agree only 38,9%, however, those with more
than 20 years of working experience tend to agree much more (61.7%), as well as those with 25 years of working experience (69.8%).

Men agree more than women, younger than 24 years agree more than older than 45 years with the statement that “conscience can give wrong signals” (μ = 3.23, Me = 4, Mo = 4, σ = 1.59). In general, 21.5% does not agree at all.

That “conscience becomes silent if we are not listening to it” μ = 2.98, Me = 3, Mo = 1, σ = 1.86) 34.6% do not agree at all and men strongly disagree in fewer cases.

At work 44.1% of respondents “do not have to make their conscience silent if they want to continue with nursing” (μ = 2.35, Me = 2, Mo = 1, σ = 1.54). Nurse auxiliaries (completed secondary school) and nurses employed in nursing homes agree more. Respondents with less working experience agree more than others.

“Conscience is too strict” for 20.5% of respondents (μ = 3.00, Me = 3, Mo = 1, σ = 1.67), however, 29% of them do not agree at all. There is no difference between men and women. The younger the respondents are, the more they think that their conscience is too strict. Nurses employed in primary health care settings and nurses with less working experience often do not agree at all that their conscience is too strict. Nurses with more than 25 years of experience agree more.

72.8% of respondents partly or strongly agrees that “through conscience social values are expressed” (μ = 4.26, Me = 5, Mo = 5, σ = 1.54). Nurses older than 45 years and those with more than 25 years of experience tend to disagree more.

4.9% of all respondents, men more frequently, often did not respond to the statement that “god is speaking through conscience” statement (μ = 3.17, Me = 3, Mo = 1, σ = 1.90). Furthermore, men strongly disagree more frequently (42%) in comparison to one third of all respondents. The younger agree more than the older.

In most cases, the respondents strongly agree that, “when being obedient to own conscience, person is making progress as a human being” (μ = 4.82, Me = 5, Mo = 6, σ = 1.27). Younger,
those with less working experience and those employed in primary settings, agree less than older than 35 years and more educated.

79% of nurses do not “feel the pain of conscience every day” ($\mu = 1,78, M_e = 1, M_o = 1, \sigma = 1,17$), men less often than women.

Agreeing with the statement “When I cannot respond to my demands to myself I have bad conscience” varies ($\mu = 3,43, M_e = 4, M_o = 4, \sigma = 1,61$). Those younger than 24 years and nurse auxiliaries agree more, older than 45 years and more educated agree less or they strongly disagree.

5.6. Discussion

Realization of the sample was 19,3%. One of the reasons for low response rate is probably the fact that together with questionnaire about conscience, extensive questionnaire (it required approximately 45 minutes to be completed) about ethics of Slovene nurses was also sent out to the same sample. Required amount of time for the green questionnaire most probably caused low response rate because getting two questionnaires at once was too intimidating and time consuming for the respondents. Sending of the two: yellow and green questionnaires at once in the same envelope was entitled because of lower expenses. Another reason for low response rate could be the topic debated in the questionnaires. Conscience and pain of conscience is often mentioned in everyday life, but they are not deeply discussed as questionnaire demanded.

Sample size was adequate to answer the research question, which was for the empiric part of the study to describe how Slovene nurses perceive and explain the concept of conscience. Within the research group in Sweden and Slovenia it was agreed that this study was carried out on a suitable sample and that low response rate is still acceptable. Reasons for being satisfied with 19,3% gained response rate is the number of respondents, which is 483 and still very high for such survey.

Majority of Slovene nurses do not feel bad conscience every day. They think that conscience needs to be interpreted and cannot be avoided. It protects us against hurting others and
ourselves. Conscience should be obeyed without considering opinions of others. Results showed that Slovene nurses have difficulties to act as conscience directs them at work place. Reasons for that could be found in Slovene nurses’ subordination to physicians, where nurses rarely get the opportunity to express their own ideas (Ule, 2003). At the same time they claim they have no need to suppress conscience at work.

Evidently, they are not determined if they can tell what their conscience is saying to them on their work place, however, they can follow it at work place, as well, despite their affirmation to make conscience silent at work. Because of the tensions from physicians and patients, are nurses forced to narrow their empathic relationships with patients. Their integrity of conscience is the hard to maintain, much harder than for other health professionals (Curtin, 1993). However, it is expected that nurses would feel and understand the patients more than other employed.

They are not sure if the conscience can give wrong signals. However, nurses are certain that conscience does not become silent if we are not listening to it; as it is also debated by Heidegger who sees conscience as a silent call which becomes an emissary of nothingness (Schalow, 1995). This silent call is by saying nothing provoking individual, who cannot ignore it.

Respondents were sensitive to the question with reference to religion. The rate of missing responses was high and it is possible to make inference that some nurses are inseparable connecting conscience to religion, saying that “the people who are not religious have conscience as well” in the open question. It is also plausible that respondents find subject of religion to personal to answer. 57,8% of Slovene population is member of catholic religion in the year 2002 (http://www.stat.si/popis2002). Percent has from previous counting decreased for 13,8%.

Among Slovene nurses differences in gender, age, education, years of work experience have shown evidently. Differences on the basis of work settings were not so often perceived. Younger nurses and nurses with less work experiences cannot avoid conscience more often than others. They are also often stating that they cannot tell what their conscience is saying to them on their work place and that they more often cannot follow their conscience at work, which logically shows that they have less power in comparison to others. Young nurses are
more convinced that conscience gives wrong signals; therefore they perhaps think also that their conscience is too strict.

Nurses with many years of experience think that it is not necessary to interpret conscience, they do not need peace to hear it and can act sovereigntly at their work place by telling about their conscience at work place, where they can also follow it better than younger nurses. Older nurses also do not have bad conscience if they cannot fulfill their own demands, which is in contradiction to theories of formation and internalization of conscience. Those theories argue for the power of ethical and altruistic behavior even long after death of person’s parents. Parents’ demands become own personal demands during the process of internalization (Kochanska, 1994). The difference in comprehension of conscience and pain of conscience reflect differences in cultural upbringing. Conscience can be misled for example by propaganda or distorted by fear, force, terror, deprivation, addiction or psychological distress (Kavanaugh, 1997).

Nurses with higher school and faculty level of education feel necessity of interpreting conscience. They also think conscience protect us against hurting ourselves more than the rest of the nurses, they estimate that they cannot follow their conscience at their work place to the extent they would like to. Nurse auxiliaries also feel bad conscience more when they cannot fulfill their own demands.

Men are more convinced that they can avoid conscience and especially strongly disagree that they can present what their conscience is saying to them at work. Men more often think that conscience can give wrong signals and that we can suppress conscience by not listening to it. In general, men feel less pain of conscience than women. There was not found any literature about the influence of gender on strictness of pain of conscience.

6. METHODOLOGICAL CONSIDERATIONS

According to Hinton (2004) reliability is defined as the ability of measuring instrument to measure the concept in a consistent manner, and the extent to which a measure, procedure or instrument yields the same result on repeated trials (http://writing.colostate.edu/).
Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher attempts to measure. While reliability deals with the accuracy of the actual measuring instrument or procedure, validity deals with with the study's success at measuring what the researchers set out to measure (http://www.socialresearchmethods.net/).

6.1. Internal reliability

Internal consistency is the extent to which tests or procedures assess the same characteristic, skill or quality. It is a measure of the precision between the observers or of the measuring instruments used in a study. This type of reliability often helps researchers interpret data and predict the value of scores and the limits of the relationship among variables (http://writing.colostate.edu/).

One measure of reliability is called split-half reliability analysis, where the answers on the first half of the questionnaire are compared to the answers on the second half of the questionnaire. If there is high correlation between two halves of the questionnaire, we can argue that there is internal consistency in the questionnaire (Hinton, 2004).

<table>
<thead>
<tr>
<th>RELIABILITY ANALYSIS - SCALE (SPLIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliability Coefficients</td>
</tr>
<tr>
<td>N of Cases = 409,0</td>
</tr>
<tr>
<td>Correlation between forms = .3259</td>
</tr>
<tr>
<td>Guttman Split-half = .4906</td>
</tr>
<tr>
<td>9 Items in part 1</td>
</tr>
<tr>
<td>Alpha for part 1 = .5133</td>
</tr>
</tbody>
</table>

In conscience questionnaire 9 items were in part one and 8 items in part two, valid cases were 409. Alpha for part one was 0,5133 and for part two it was 0,5818. Corellation between two halves of the conscience questionaire is not particularly high, however, it can be argued that the questionaire has pretty good internal consistency. This limited questionaire data is therefore assumed as reliable.
Another coefficient of reliability (or consistency) is Cronbach's alpha, which examines the average inter-item correlation of the items in the questionnaire and also takes into account the number of items in the questionnaire. Alpha coefficient ranges in value from 0 to 1 and may be used to describe the reliability of factors extracted from dichotomous and/or multi-point formatted questionnaires or scales. The higher the score, the more reliable the generated scale is. It is conventional to view the Cronbach's alpha of 0.7 or more as indicating a reliable scale (Hinton, 2004). There are many different ways to estimate reliability but Cronbach's alpha is one of the most commonly used coefficients as a measure of the internal consistency of the test. In general the more questions there are, the more reliable the test is.

Cronbach's alpha coefficients were subsequently calculated for each question (17 questions) and ranged from 0.62 to 0.66. Number of valid responses was 409.

<table>
<thead>
<tr>
<th></th>
<th>Reliability Analysis (Alpha)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N of Cases</td>
<td>409</td>
</tr>
<tr>
<td>N of Items</td>
<td>17</td>
</tr>
<tr>
<td>Alpha</td>
<td>0.6492</td>
</tr>
</tbody>
</table>

Reliability analysis of the conscience questionnaire estimated Cronbach’s alpha coefficient 0.6492. This value of Cronbach’s alpha coefficient although closing to borderline values (0.7) is acceptable.

6. 2. Validity of conscience questionnaire

External validity refers to the extent to which the results of a study are generalizable or transferable. Transferability is the ability to apply the results of research in one context to another similar context. Many qualitative research studies are not designed to be generalized but they are transferable (http://writing.colostate.edu/).

Attempts were made to select a representative sample of Slovene nurses population to which results could be generalized or transferred. The population researched in this particular study was not sufficient to show complete overview of Slovene population of nurses due to differences in educational level between sample and population (Peternelj, 2001). In the
sample, there are 54% of the nurse auxiliaries, however, in population there are 77% (Peternelj, 2001). Reasons for better response of nurses with completed higher school and faculty could be found in the subject of the study itself. The topic is not easy to think about and the structure of questionnaire itself demands checking the respondents’ own conscience. Other sample characteristics are well-matching situation in target population. Deviation of the sample structure from ideal sample can be overcome by taking it into consideration. The sample structure problem could be solved by weightening the data. Sample size represents 18,1% of the whole Slovene nurses population and is adequate. Sample size was satisfactory, however, sample response rate was disappointing. Response rate 19,3% means that there is the risk of introducing error into the findings through non-response. Reason for low response rate could be the fact that conscience questionnaire was sent out together with very extensive questionnaire about ethics of Slovene nurses and perhaps it was simply too time-consuming to respond. Resuming all stated facts, the study has limited external validity due to certain sample characteristics connected to education; therefore the level of generalization is partly limited.

To achieve internal validity this study has rigorous study design, moreover, focus is placed on conducting measurements. Face validity as part of internal validity deals with how a measure or procedure appears. Used study design based on published results on similar studies (Soderberg, 1999, dealt with this subject), seemed like a reasonable way to gain the required information. Study design was developed in Sweden and transferred in Slovene context with necessary adaptations. It was thoroughly discussed by prof. Astrid Norberg (overall research leader), dr. Majda Pahor (research sociologist) and the author. For statistical adequacy statistician of University of Umea, Sture Eriksson was consulted. Alternative explanations for any causal relationships were taken into account and discussed. There were no contradictions identified and the conclusion of the debates was that this study design bears common sense judgement.

Construct validity seeks agreement between a theoretical concept and a specific measuring device or procedure. It can be broken down into two sub-categories: convergent validity and discriminate validity. Convergent validity is the actual general agreement among ratings, gathered independently of one another researcher, where measures should be theoretically related. Discriminate validity is the lack of relationship among measures, which should not be related theoretically. To understand whether a piece of research has construct validity, three
steps should be followed. First, the theoretical relationships must be specified. Second, the empirical relationships between the measures of the concepts must be examined. Third, the empirical evidence must be interpreted in terms of how it clarifies the construct validity of the particular measure being tested (http://writing.colostate.edu/). Construct validity in this study was measured with split-half and Cronbach’s alpha reliability analysis, which are most commonly used and its result acceptable in terms of statistical analysis of the type of samples we had.

7. GENERAL DISCUSSION

General conclusion of performed literature review is that in nursing research the field of conscience is not present to a great extent, therefore it is hard to give a complete insight about the position of concept of conscience in nursing. In future, this concept would pose a challenge to nursing researchers and would help to explain how bad or good conscience is influencing the performing of nursing. Number of aspects need to be described and their mechanisms clarified. Nurses often confront with their conscience when performing nursing, which increases the possibility to have bad conscience and to be in conflict with it, which was also confirmed during this study.

Systematic sampling as conducted in second study is essentially identical to simple random sampling and in most cases is preferable because the same results are obtained in a more convenient and efficient manner (Polit et al, 2001). Most quantitative studies are based on samples of fewer than 200 subjects, and a great many studies have fewer than 100 subjects (Polit et al, 2001) therefore this study with 483 respondents meets criteria about sample size. Because of the first use the conscience scale in the present study was considered acceptable. Participants were responding to different items (questions) in a consistent manner. However, which result of Cronbach’s alpha is acceptable, varies among different disciplines. Cronbach’s alpha coefficient for the whole conscience questionnaire was 0,6492 and was adequat though not especially high. After consultation with Swedish and Slovene part of the research group, although closing to borderline values this value it was considered to be acceptable for the purpose of this exploratory research.
Second study has confirmed that conscience is influencing performing nursing as it was ascertained in previous studies (first study). It has shown that Slovene nurses are occupied with thinking about how things are done and how they should be done. However, they often do not have the power to speak about what their conscience is saying about these actions (Ule, 2003). Integrity of their conscience seems to be limited. One who is said to have a well-developed conscience has a disposition to act in accordance with his moral beliefs. Such a person is said to have integrity. Person should be free to act on own moral beliefs (McConnel, 1996), but this must be enabled to nurses in their work environment.

Sympathy with the other man is the basis of conscience (Tillich, 1963) and is one of the core components in nursing. Nurses think conscience needs to be interpreted, which could be mainly realized into everyday praxis. Whole philosophy of the health care institution is important when it comes to the questions of ethics and conscience, therefore implementation of debates about conscience have to start with leaders stimulating discussions about this topic. Identifying with other persons, taking their approval/disapproval of our actions, provoke own judgments (Tillich, 1963) to help us to interpret what our conscience is saying to us.

Several authors (Kavanaugh, 1997, Costigane, 1999 and McConnel, 1996) agree about the inalienability of conscience. Not having peace in mind for hearing the conscience is not necessary for Slovene nurses as well as for Heidegger (Schalow, 1995). Consequently nurses cannot avoid the conscience: it was internalized into them as they were small kids and it is loud at all times also in adulthood age. Nurses as an individuals are experiencing guilt if acting in contrary to what conscience demands (Mosher, 1979). Slovene nurses have to give more attention to maintaining their integrity of conscience. Nurses as moral persons need social space. Their behaviour and situation at work can cause destruction of their personal integrity influencing the quality of their work and relationships both with colleagues and patients. Nurse’s professional conscience has to be protected in order to maintain nurses integrity and its inalienability must be assured as they are convinced that their conscience should be obeyed without considering opinions of others. This result also alludes level of certainty of nurses that their conscience is not being fallible. Tillich (1963) advocates the fact that person is having infallible knowledge about the moral principles, natural law, but at the same time he is admitting man’s conscience is to fall into error in every concrete situation.
Many Slovene nurses cannot tell what the conscience is saying to them in the work place, which is believed to violate their integrity of conscience. Only two thirds of Slovene nurses can on the whole follow their conscience at work. In the first case conscience protects Slovene nurses to protect them against hurting others and than it the second case against hurting themselves. Painful memory of past guilt is likely to prevent person from performing and similar action again (Leal, 1999). Conscience is not possible to silence. One fifth of Slovene nurses feel that their conscience is too strict, which anticipates they are heavily burdened by guilt. Still majority does not feel the pain of conscience every day. Through conscience social values are expressed and lack of conscience development is a grave societal concern (Meyer, 1998).

8. IMPLICATIONS AND CONCLUSION

It can be concluded that the credibility and accuracy of the results is satisfactory. All considered validity and reliability of the studies presented in this paper bare to assess that results of the studies are accurate and believable. Reason for discrepancy of results is limited possibility to generalize the results to whole Slovene nurses population. Results could be generalized to certain extent allowing taking into account the educational level differences.

Results of the studies mean contribute to illumination of concept of conscience in research about nurses in literature resources and to description of how Slovene nurses perceive and explain the concept of conscience. Presented results are important for outset guidance to further research projects on conscience and related topics, which needs to be done.

Conscience in nursing is implemented in every action of a nurse, it must be stimulated to be more present in professional debates and most important is to enable nurses to maintain their integrity of conscience. Arousing pain of conscience is a form of control. Development of the dimension of connection between good and bad conscience must be discussed more. Slovene nurses have decreased opportunities to do that because of the current position of nursing in Slovene health care system.
9. REFERENCES

http://www.library.ncat.edu/ref/guides/literaturereview03.htm, 13.4. 2005


Peternelj K. *Nurses in Slovenia: research sample presentation* /Medicinske sestre v Sloveniji: predstavitev raziskovalnega vzorca*. In Klemenc D, Pahor M. *Nurses in Slovenia* /Medicinske


Vacek E. Do 'Good People' Need confession? America; 2002; 186(6): 11-17.

10. APPENDIXES

Appendix 1

Approval from ethical commission (original and translation)

Original (scanned)

KOMISIJA REPUBLIKE SLOVENIJE ZA MEDICINSKO ETIKO

Darinka Klemenc, dipl. m. s.
Društvo medicinskih sester in zdravstvenih tehnikov
Zaloška 7, 1525 Ljubljana

Štev.: 69/10/03
Datum: 07. 10. 2003

Spoštovana gospa Klemenc,

Komisiji za medicinsko etiko ste 30. 9. 2003 poslali prošnjo za oceno načrta raziskave z naslovom:

"Stres, ki izhaja iz slabe vesti." Anketna študija.

KMJE je na današnji seji ocenila, da je študija z etične strani sprejemljiva, in Vam s tem izdaja svoje soglasje.

S spoštovanjem in lepimi pozdravi,

predsednik Komisije za medicinsko etiko:
prof. dr. Jože Tromelj
Translation

Picture of Slovene arm

Commission of Republic of Slovenia for Medical Ethics

Darinka Klemenc, RN

Nurses association of Ljubljana

Zaloška 7, 1525 Ljubljana (address)

Number: 69/10/03

Date: 07.10.2003

Dear Ms. Klemenc,

On 30. 9. 2003 you have sent to the Commission for medical ethics an application for ethical approval of the research plan addressed:

"Consciousness stress" Questionnaire study

CME has on today's meeting evaluated, that the study is acceptable from the ethical point of view and therefore it gives you a consensus.

With respect and nice regards,

President of Commission for medical ethics:

Prof. dr. Jože Trontelj

Signature

Address: Prof. dr. Jože Trontelj, Institute for neurophysiology, Medical Centre Ljubljana

Zaloška 7, 1525 Ljubljana, Phone: 01/522 1500, fax 01/522 1533, e-mail: joze.trontelj@kelj.si
Comment: Darinka Klemenc was at the time president of Nurses association of Ljubljana region under the patronage of which the research was carried out. CME is the only Slovene commission for ethics in the health care field and it operates within the Ministry of Health of the Republic of Slovenia. The address beneath the last line is the address of CME president's working place.
Appendix 2

Conscience questionnaire

CONSCIENCE

Please encircle the number from the scale below at each statement, which is corresponding best to your perception of conscience.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I strongly disagree.</td>
</tr>
<tr>
<td>2</td>
<td>I pretty disagree.</td>
</tr>
<tr>
<td>3</td>
<td>I partly disagree.</td>
</tr>
<tr>
<td>4</td>
<td>I partly agree.</td>
</tr>
<tr>
<td>5</td>
<td>I pretty much agree.</td>
</tr>
<tr>
<td>6</td>
<td>I strongly agree.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conscience needs to be interpreted.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>2. To hear the conscience you have to have peace in mind.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>3. We cannot avoid the conscience.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>4. Conscience protects us against hurting ourselves.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>5. Conscience protects us against hurting others.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>6. Own conscience should be obeyed without considering opinions of others.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>7. I can tell what my conscience is saying to me on my work place.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>8. I can follow my conscience at work.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>9. Conscience can give wrong signals.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10. Conscience becomes silent if we are not listening to it.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>11. I have to make my conscience silent at work if I want to continue nursing.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>12. My conscience is too strict.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>13. Through conscience social values are expressed.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>14. God is speaking through conscience.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>15. When I listen to my conscience I am making progress as a human being.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>16. I have bad conscience every day.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>17. When I cannot respond to my demands I have bad conscience.</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>Your comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Figures

Figure 1. Gender

Figure 2. Age of respondents

Figure 3. Level of education
Figure 8. We cannot avoid the conscience.

Figure 9. Conscience protect us against hurting ourselves.

Figure 10. Conscience protect us against hurting others.

Figure 11. Own conscience should be obeyed without considering opinions of others.
Figure 12. I can tell what my conscience is saying to me on my work place.

Figure 13. I can follow my conscience at work.

Figure 14. Conscience can give wrong signals.

Figure 15. Conscience becomes silent if we are not listening to it.
Figure 16. I have to make my conscience silent at work if I want to continue nursing.

Figure 17. My conscience is too strict.

Figure 18. Through conscience social values are expressed.

Figure 19. God is speaking through conscience.
Figure 20. When I listen to my conscience I am making progress as a human being.

Figure 21. I have bad conscience every day.

Figure 22. When I cannot respond to my demands I have bad conscience.
Acknowledgments

I am grateful to dr. Liisa Palo Bengtsson for supervising of writing of this thesis, to prof. dr. Sirkka Liisa Ekman and prof. dr. Astrid Norberg for constructive and fruitful discussions. Also I am grateful to dr. Majda Pahor, for all the support and guidance during conducting research and Nurses Association of Slovenia for valuable data.

Thanks for kind support and help of Peter Zabukovnik and Andreja Petrenelj and Tanja Dre.0.